

## Pulmonary and Sleep Medicine Center of Winder

20 Satellite Dr. Ste 200, Winder, GA 30680

Phone (770) 586-0300, Fax (770) 586-0311

### **ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I acknowledge my receipt of *Pulmonary and Sleep Medicine Center of Winder's Notice of Privacy Practices* which is posted in the office and on the practice's website ([www.PulmonarySleepMed.com](http://www.PulmonarySleepMed.com)) and give my consent for *Pulmonary and Sleep Medicine Center of Winder* ("PSMCW" or "practice") to use and disclose protected health information about me to carry out treatment, payment, and healthcare operations.

I understand and acknowledge that the PSMCW's *Notice of Privacy Practices* provides a more complete description of such uses and disclosures than the examples provided in this consent form and that I have the right to review the *Notice of Privacy Practices* prior to signing this consent.

I understand and acknowledge that PSMCW reserves the right to revise its *Notice of Privacy Practices* at anytime and that a revised *Notice of Privacy Practices* may be obtained by sending a written request to PSMCW at the following address: Attn: Dr. Rami Arfoosh, CEO and Privacy Officer, *Pulmonary and Sleep Medicine Center of Winder.*, 20 Satellite Dr. Ste 200, Winder, GA 30680.

PSMCW may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as appointment reminders, insurance items, patient statements, and any calls pertaining to my clinical care, including, without limitation, laboratory results among others.

PSMCW may mail or email to my home or other alternative location any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as appointment reminder cards and patient statements.

I understand and acknowledge that I have the right to request that PSMCW restricts how it uses or discloses my protected health information to carry out treatment, payment, and healthcare operations. I understand and acknowledge that PSMCW is not required to agree to my requested restrictions, but if it does, it is bound by this request.

I understand and acknowledge that this consent does not expire on its own. I may revoke my consent in writing, except to the extent that the PSMCW has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, PSMCW may decline to provide treatment to me.

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Signature of Patient or Legal Guardian

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Date of Birth

\_\_\_\_\_  
Print Name of Patient or Legal Guardian

\_\_\_\_\_  
Date