PRIMARY MEDICAL SERVICES, P.C.
FAMILY MEDICINE & URGENT CARE
PATRYCJA CZESNOWSKI, M.D.

PATIENT CONSENT FORM

Effective April 14, 2003 per Health Insurance Portability and Accountability Act of 1996 (HIPPA)
Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Dr. Czesnowski, M.D., to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Dr. Czesnowski, M.D., describes such uses and disclosures more completely).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Czesnowski, M.D., reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Czesnowski, M.D.

With this consent, Dr. Czesnowski, M.D., may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice to carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results.

With this consent, Dr. Czesnowski, M.D., may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked, "Personal and Confidential."

With this consent, Dr. Czesnowski, M.D., may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Dr. Czesnowski, M.D., restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Dr. Czesnowski, M.D., to use and disclose my PHI to carry out TPO. I also allow Dr. Czesnowski, M.D., to transfer digital images of my person over e-mail for the express, sole purpose of providing visual imagery to a consulting physician involved in my care. I realize that e-mail is not 100% secure but understand that Dr. Czesnowski, M.D., will do everything reasonably possible to assure that this information and imagery remains protected.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Dr. Czesnowski, M.D., may decline to provide treatment to me.

_____	_____	Date: _____ / _____ / _____
Signature of Patient/Legal Guardian	**Relationship to Patient**	
_____	_____	
Print Patient's Name	**Print Name of Legal Guardian**	

*** Parent/Guardian must be provided with a signed copy of this authorization/consent form.

24503 JOHN R ROAD * HAZEL PARK * MI * 48030
PHONE (248) 629-6440 * FAX (248) 629-6445