BLUEGRASS INTERNAL MEDICINE

PATIENT NAME:_____DATE OF BIRTH:_____

PERSONAL REPRESENTATIVE:
I authorize Bluegrass Internal Medicine to give to my personal representative(s), as named below, protected health information on my behalf.
NAME RELATIONSHIP

_____

_____

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PLEASE CHECK ALL THAT APPLY:
I wish to be contacted about my protected health information in the following manner:

- **Home Telephone #_____**
- **Cell Phone #_____**
- **Written Communication (Mail)**
- **Work Telephone #_____**
- **Other:_____**

I acknowledge that I have received a copy of the Notice of Privacy Practices of Bluegrass Internal Medicine.

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CONSENT: I hereby consent to Bluegrass Internal Medicine using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out Bluegrass Internal Medicine health care operations. I authorize examination and any other medical services deemed necessary by the physician. I authorize the release of any protected health information to another physician or my insurance company, unless specifically requested in writing by me. This protected health information includes any personal or confidential information of a sensitive nature such as psychological or psychiatric records, substance abuse, drug or alcohol treatment or information pertaining to communicable diseases (including HIV status, hepatitis, or venereal diseases). I understand and agree to these conditions as a patient of Bluegrass Internal Medicine.

PATIENT SIGNATURE:_____

PERSONAL REPRESENATIVE (IF APPLICABLE):_____

WITNESS:_____TODAY'S DATE_____