

**PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED  
HEALTH INFORMATION**

**LAGRAIZE MEDICAL, LLC**

With my consent, LaGraize Medical, LLC may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to LaGraize Medical, LLC Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. LaGraize Medical, LLC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to LaGraize Medical, LLC Privacy Officer at 155 Hospital Dr Ste 410, Lafayette LA 70503.

With my consent, LaGraize Medical, LLC may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, LaGraize Medical, LLC may mail to my home or other designated 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.

However, the practice is not required to agree to my requested restrictions, if it does, it is bound by this agreement.

By signing this form, I am consenting to LaGraize Medical, LLC use and disclosure of my PHI to carry out TPO.

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, LaGraize Medical, LLC may decline to provide treatment to me.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Date