CARROLL HEALTH GROUP

A LifeBridge Health Partner

General Surgery

Consent & Disclosure

Patient Consent For Alternate Contact & Patient Information Exchanges

I hereby give my consent for Carroll Health Group, LLC (CHG) to disclose protected health information ("PHI" including, for instance, appointment reminders or test results) about me or my dependent to the following trusted persons in conformance with CHG's Notice of Privacy Practices ("NPP"). CHG's NPP more completely describes *why* and *how* such information may be disclosed.

I have the right to review the Notice of Privacy Practices prior to signing this consent. CHG and its affiliates reserve the right to revise the Notice of Privacy Practices at any time.

Name: ______________________________

Relation to Patient: ___________________

Phone Number: ______________________

Name: ______________________________

Relation to Patient: ___________________

Phone Number: ______________________

Name: ______________________________

Relation to Patient: ___________________

Phone Number: ______________________

Name: ______________________________

Relation to Patient: ___________________

Phone Number: ______________________

Health Information Exchanges. We may participate in health information exchanges to facilitate the secure exchange of your electronic health information between and among several health care providers or other health care entities for your treatment, payment or other health care operations purposes. This means we may share information we obtain or create about you with outside entities (such as hospitals, doctors' offices, pharmacies or insurance companies) or we may receive information they create or obtain about you (such as medication history, medical history or insurance information) so each of us can provide better treatment and coordination of your health care services. If you wish to opt out, please ask an associate for information that will instruct you on how to do so.

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Signature of Patient or Legal Guardian

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Date

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Print Patient's Name

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Print Name of Legal Guardian (if applicable)

For office use only:

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CHG Associate   Date Received

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