



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

I hereby give my consent for ATHENS THERAPEUTICS to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). ATHENS THERAPEUTICS'S Notice of Privacy Practices provides 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. ATHENS THERAPEUTICS 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 ATHENS THERAPEUTICS Privacy Officer at 1551 Jennings Mill Rd., Suite 1700A, Bogart, GA 30622.

With this consent, ATHENS THERAPEUTICS 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, ATHENS THERAPEUTICS may e-mail to my home or 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 ATHENS THERAPEUTICS restrict how it uses or discloses my PHI to carry out TPO. However, 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 ATHENS THERAPEUTICS'S 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, or later revoke it, ATHENS THERAPEUTICS may decline to provide treatment to me.

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

\_\_\_\_\_  
Date

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