COASTAL HEADACHE CLINIC

Compassionate Headache and Migraine Care

PHONE (910) 238-2050
FAX (910) 238-2310

1715-B COUNTRY CLUB RD
JACKSONVILLE, NC 28546

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Coastal Headache Clinic (the Practice) to use and disclose my protected health information (PHI) to perform treatment, payment and health care operations (TPO).

With this consent, the Practice may call me or email me to my home or other alternative location and leave a message by voice, email or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and anything pertaining to my clinical care, including laboratory test results.

With this consent, the Practice may mail to my home or other alternative location any items that assist the practice in performing TPO, such as appointment reminder cards, patient statements and anything pertaining to my clinical care as long as they are marked “Personal and Confidential.”

By signing this form, I am consenting to allow the Practice to use and disclose my PHI to carry out TPO.

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

Patient Name: ____

Signature of Patient
(or Legal Guardian): ________________________________ **DATE:** __________________