HIGH MOUNTAIN HEALTHCARE, LLC
63 Pleasant Hill Road
Blairsville, GA 30514

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Patient Consent for Use and Disclosure of PHI

I hereby give my consent for High Mountain Healthcare providers (listed above) to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by High Mountain Healthcare describes such uses and disclosures more completely.) I have the right to review the Notice of Privacy Practices prior to signing this consent. High Mountain Healthcare reserves the right to revise its Notices of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Privacy Officer, High Mountain Healthcare P.O.Box 2239, Blairsville, GA 30514, or by requesting a copy in person.

With this consent, the physicians and staff of High Mountain Healthcare may call my home or other alternative numbers I have provided and speak with me or leave a message on an answering machine, voice mail or with a family member or caregiver in reference to, but not limited to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance and billing items including collection calls and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, High Mountain Healthcare providers 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 other patient statements. I have the right to request that High Mountain Healthcare providers restrict how it uses or discloses my PHI to carry out TPO. 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 allow High Mountain Healthcare providers 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 in reliance upon my prior consent. If I do not sign this consent, or later revoke it, High Mountain Healthcare, LLC may decline to provide treatment to me. I acknowledge that I have received the practice's Notice of Privacy Practices and have been provided an opportunity to review it.

_______________________________ Print Patient's Name

_______________________________ Print Legal Guardian's Name if applicable

_______________________________ Patient or Legal Guardian's Signature

_______________________________ Date

INSURANCE AUTHORIZATION

I hereby assign and authorize payment to High Mountain Healthcare, LLC and/or Suzanne L. Nunn MD, PC of medical and/or surgical benefits, including major medical benefits, to which I am entitled and under any insurance policy or policies, under any self-insurance program or under any other benefit plan. I authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS confidential information, necessary to process insurance claims or any medical information that is required for any health care related utilization or quality assurance activities. I agree to pay for all charges not covered by my insurance.

MEDICARE PATIENTS: I request payment of authorized Medicare benefits on my behalf of any services furnished to me by the physicians and physician assistants of High Mountain Healthcare, LLC and/or Suzanne L. Nunn MD, PC. I authorize any holder of medical information about me to release to the Health Care Financing Administration (Medicare) and its agents any information needed to determine these benefits or the benefits payable for related services. This authorization shall remain in effect until revoked by me in writing. A photocopy or scanned image of this authorization shall be considered as effective and valid as the original.

_______________________________ Patient or Legal Guardian's Signature

_______________________________ Date