Naturally Healthy Family Medicine
Robert H. Hall, M.D., P.A.
7637 Lancaster Pike
Hockessin, DE 19707

Patient Consent and Acknowledgement of Receipt of Notice of Privacy Practices

You have the right to know how your medical information, also known as **Protected Health Information (PHI),** is going to be used and your rights concerning that information. For a more detailed account of our policies and procedures concerning privacy of medical records, refer to our Notice of Privacy Practices. Please read the following information and if you agree with its content, sign at the bottom of the page. Thank you.

1. Your signature below will indicate to us that you agree to allow our office to use your PHI for the purpose of treatment, payment, healthcare service, coordination of care and other purposes as outlined in this consent.
2. It is only necessary for you to give your consent once. Your consent will remain in effect until you revoke it in writing.
3. You can revoke this consent by advising our office in writing that the consent is revoked.
4. By signing this "**Patient Consent**" form you agree that our office may provide the following services involving your medical records.
    a. We may call you, email you, leave messages on your answering machine(s) and/or send you letters or postcards to remind you of appointments.
    b. We may call you and discuss treatment as well as test results.
    c. We may contact you about new services or special events that occur at our office.
    d. We may contact you via email with newsletters (our newsletters are sent only via email) and/or in response to your correspondence.

By signing below, I am indicating that I have received and understand the **Notice of Privacy Practices.** I have read and understand how my Protected Health Information will be used; and I consent to these policies and procedures.

_____
Name of Patient (please print)

_____
Signature (of patient or parent/guardian, if patient is a minor)

_____
Date