

**Piedmont Psychiatric Clinic**

35 Collier Road N.W., Suite M-215  
Atlanta, Georgia 30309-1613  
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"www.piedmontpsychiatricclinic.com"

Adult, Adolescent, Family and Administrative Psychiatry

Dave M. Davis, M.D., D.L.F.A.P.A., F.A.B.F.P., F.A.B.P.N.

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**Patient Consent to the Use and Disclosure of Protected Health Information  
Regarding Treatment, Payment, or Healthcare Operations**

I understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals including pharmacies who contribute to my care
- A source of information for applying my diagnosis to my bill
- A means by which a third-party payer can verify that services billed were actually provided and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals
- Authorization to call or mail information to my home or other alternative locations any items that assist the practice in carrying out TPO, appointment cards, statements as long as they are marked Personal and Confidential

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will post a copy of any revised notices. I understand that I have the right to object to the use of my health information for directory purposes. Understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, healthcare operations including prescriptions and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. If I do not sign this consent, or later revoke it, Piedmont Psychiatric Clinic and its' providers may decline to provide treatment to me.

Please forward all written correspondence to:

ATT: Office Manager  
Piedmont Psychiatric Clinic  
35 Collier Road N.W., Suite M-215  
Atlanta, GA 30309-1613

I wish to have the following restrictions to the use or disclosure of my health information:

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Print Patient or Legal Guardian

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Patient or Legal Guardian Signature

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Date Patient or Legal Guardian Signed Consent

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Signature of Witness

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Date Witnessed