GEORGETOWN INTERNAL MEDICINE
1138 LEXINGTON ROAD, SUITE 290
GEORGETOWN, KY 40324

Matthew C. Birdwhistell, D.O.
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Patient Name: _____

Address: _____

City, State, Zip _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employment: _____ Occupation: _____

Social Security No. _____ Date of Birth: _____ Sex: ____ Marital Status: _____

Tobacco Use(Circle One): Y, N, Quit Preferred Language: _____ Email Address: _____

Race (Circle One): American Indian or Alaskan Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, Other, White, Patient Refuse

Ethnicity (Circle One): Hispanic or Latino, Not Hispanic or Latino, Patient Refuse

Who should be notified in the case of an emergency:

Name: _____ Phone No.: _____

I hereby consent to Georgetown Internal Medicine (the "Practice") using or disclosing my protected health information ("PHI"), including PHI containing Chemical Dependency/Substance Abuse, Sexually Transmitted Diseases, Drugs and Alcohol for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out the Practice's health care operations. I also consent to the Practice using or disclosing my protected health information, including PHI containing Chemical Dependency/Substance Abuse, Sexually Transmitted Diseases, Drugs and Alcohol for treatment activities provided by another health care provider, as well as the payment activities conducted by another health care provider or entity. I further consent to the disclosure of my protected health information, including PHI containing Chemical Dependency/Substance Abuse, Sexually Transmitted Diseases, Drugs and Alcohol in order for another provider or health care entity to conduct health care operations including quality assessment and reviewing the competence of health care professionals.

I authorize payment of medical benefits to be made directly to supplier or physician for services performed.

I further acknowledge the Practice has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

_____
Signature of Patient or Personal Representative

_____ _____
Name of Patient or Personal Representative Description of Personal Representative's Authority

_____
Date