MRN#________________________

Calvert Internal Medicine Group

__________________________________, have been offered a copy of Calvert Internal Medicine Group
(Please Print Name)
Notice of Privacy Practices. I have been advised of how health information about me may be used and disclosed by the medical group listed at the beginning of this notice, and how I may obtain access to and control of this information.

By signing below, I also consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations for the medical group, its staff and its business associates.

Signature of patient/parent or Guardian:____

Description of Personal Representative Authority:____

Date:______________________________

Effective Date 4/26/2017