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EXHIBIT B
GUAM COMMUNITY HEALTH CENTERS
(Northern and Southern Region Community Health Centers)

Patient Consent for Use and Disclosure
Of Protected Health Information

With my consent, the Guam Community Health Centers (GCHCs) may use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). Please refer to the Guam Community Health Centers "Notice of Privacy Practices" for a more complete description of such uses and disclosures.

I have the right to review the "Notice of Privacy Practices" prior to signing this consent. The Guam Community Health Centers reserve the right to revise its "Notice of Privacy Practices" at anytime. A revised "Notice of Privacy Practices" may be obtained by forwarding a written request to Dr. William Weare, Privacy Officer at 162 Abman Drive, Inarajan, Guam 96915.

With my consent, the Guam Community Health Centers may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the GCHCs in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent the GCHCs may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and statements of account as long as they are marked "Personal and Confidential"

With my consent, the GCHCs may send appointment reminder cards, and/or statements of account via e-mail to my home or other designated location that assist the GCHCs in carrying out TPO. I have the right to request that the GCHCs restrict how it uses or discloses my PHI to carry out TPO. However, the Guam Community Health Centers are not required to agree to my requested restrictions.

By signing this form, I am consenting to the GCHCs use and disclosure of my PHI to carry out treatment, payment, and health care operations.

I may revoke my consent in writing except where the GCHCs have already made disclosures in reliance on my prior consent. If I do not sign this consent, the GCHCs may decline to provide treatment to me.

Print Name of Patient or Legal Guardian: _____

Patient or Legal Guardian Signature: _____

Date: _____