CONSENT FOR DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Information

Name of Patient(s): _____Phone Number: _____

Address: _____

Section B: To the patient- Please read the following statements carefully

Purpose of Privacy Practice: You have the right to read our complete Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. **Upon request, a copy of our complete Notice accompanies this Consent. This consent is posted in our waiting room.**

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain in our office.

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment from you or a collection agency and to provide information to your insurance company.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization you may revoke it in writing at any time.

Family and Friends: We must disclose your health information to you. We may disclose your health information with a family member, friend or any other person to the extent necessary, but only if you agree that we do so.

Please List any persons you would like to share your personal health care information with on the lines below:

_____ _____ _____ _____

Persons Involved In Care: We may use or disclose health information to notify, or assist your personal representative or a person responsible for your care. In the event of your incapacity or emergency circumstances, we will disclose healthcare information that is directly relevant to the person's involvement in your healthcare. We will make decisions based on the use of our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up any health care information.

Required by Law: We may use or disclose your health care information when we are required to do so by law.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

You have the right to Revoke this consent at any time by giving us a written notice of your revocation. Please understand that revocation of this consent will not affect any action we took in reliance on this Consent before we received our revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

I, _____ have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

SIGNATURE: _____DATE:_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____Relationship to Patient:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT, AFTER YOU SIGN IT.