## 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 follo	owing statements carefully
•	t to read our complete Notice of Privacy Practices before you decide
	des 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 informati	on. 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 pra	ctices as described in our Notice of Privacy Practices. If we change our
	of Privacy Practices, which will contain the changes. Those changes may
apply to any of your protected health informat	
	n information to a physician or other healthcare provider providing
treatment to you.	
Payment: We may use and disclose your health	n information to obtain payment from you or a collection agency and to
provide information to your insurance compan	y.
Your Authorization: In addition to our use of your	our health information for treatment, payment or healthcare operations,
you may give us written authorization to use yo	our health information or to disclose it to anyone for any purpose. If you
give us an authorization you may revoke it in w	riting at any time.
Family and Friends: We must disclose your hea	alth information to you. We may disclose your health information with a
family member, friend or any other person to t	he extent necessary, but only if you agree that we do so.
Please List any persons you would like to shar	e your personal health care information with on the lines below:
Persons Involved In Care: We may use or discl	ose health information to notify, or assist your personal representative or
a person responsible for your care. In the ever	nt 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 pe	erson 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 discle	ose your health information to provide you with appointment reminders
(such as voicemail messages, postcards, or lette	ers).
You have the right to Revoke this consent at a	ny 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 decli	ine to treat you or to continue treating you if you revoke this consent.
I, have had full opport	tunity to read and consider the contents of this Consent form and your
Notice of Privacy Practices. I understand that, b	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 represe	ntative on behalf of the patient, complete the following:
Personal Representative's Name:	Relationship to Patient: