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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

NAME: _____

SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

PURPOSE OF CONSENT: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

NOTICE OF PRIVACY PRACTICES: You have the right to read our 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 notice accompanies this consent. We encourage you to read carefully and completely before signing this consent.

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

I,_____, have received a copy of this office's Notice of Privacy Practices. I have had full opportunity to read and consider the contents of this consent form and 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 health care operations.

PRINT NAME: _____

SIGNATURE: _____

DATE: _____