CONSENT for USE & DISCLOSURE of HEALTH INFORMATION

Name:____ Date:____________________

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 sing 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. A copy of our Notice accompanies this Consent. We encourage you to read carefully and complete before signing this Consent.

RIGHT TO REVOKE

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

SIGNATURE

I have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that by signing this Consent form that 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:____________________

Representative's Name:________________________________ Relationship to Pt:__________

(Revised 4/27/2022~cr)