Consent for Use and Disclosure of Personal Health Information

This form authorizes us to use and disclose your protected health information (PHI) for the purposes of healthcare operations, treatment and payment activities.

Before signing, please read our Notice of Privacy Policies to gain a clear understanding of how we may use and disclose your PHI.

For questions concerning our Notice of Privacy Policies, please contact:

(*Contact Person*). You may reach (*him/her*) by (*telephone, fax, e-mail, address*).

Patient's Consent

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (_____) _____ E-mail: _____

Patient #: _____ Social Security #: _____ _____ _____

I, _____, have read your Notice of Privacy Policies and I consent to your use of my PHI for the purposes of healthcare operations, treatment and payment activities.

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

Personal Representative's Name: _____

Relationship to Patient: _____

Signature: _____ Date: _____

Patient's Revocation

By signing below, you revoke your above consent for us to use and disclose your PHI. However, by doing so, we reserve the right to discontinue treatment for you. This revocation also does not negate any of our prior actions while acting under your consent.

Signature **to revoke authorization**: _____ Date: _____

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

Personal Representative's Name: _____

Relationship to Patient: _____