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PATIENT CONSENT FORM
FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

Date: ______________________

Patient Name: First ____________________________ **Last** ____________________________

I consent to the use of disclosure of my individually identifiable health information as described below. I understand that this consent is voluntary.

1. I understand that my individually identifiable health information may be used and disclosed to carry out treatment, payment or health care operations.

2. I understand that the Notice of Privacy Policies provides a more complete description provides a more complete description of the types and uses and disclosures and that I have the right to review this Notice before signing this consent.

3. I understand that the terms of this notice may change. A revised copy of the Notice of Privacy Policies may be requested from the Office Administrator.

4. I understand that I may request that the covered entity restrict how my individually identifiable health information is used or disclosed to carry out treatment, payment or health care operations. The covered entity is not required to agree to the requested restrictions, but if the covered entity agrees to the requested restriction, the restriction is binding on the covered entity.

5. I understand that I may revoke this consent at any time by notifying the covered entity in writing, except to the extent the covered entity has taken action in reliance on the consent.

Signature of Patient or Patient's Representative:

____ **Date:** ___/_____/____

Patient

____ **Date:** ___/_____/____

Patient's Representative

____   ________________________________

Print Name of Patient   **Relationship To Patient**