NAME_____ D.O.B._____

Please read this section 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 uses and disclosures, and of other important health matters about your protected health information.

We reserve the right to change our privacy practices as described in our Notice of Privacy practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy, including any revisions, of our Notice at any time.

Right to Revoke: You have the right to revoke this consent at any time by giving us written notice. 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 if you revoke this consent.

I have had full opportunity to read and consider the contents of this consent form and your notice

Of Privacy Practices. I understand that by signing this consent form, I am giving my consent for your use and disclosure of my protected health information to carry out treatment, payment activities and health care options.

SIGNATURE_____DATE _____

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

Personal representatives name_____

Representative to the patient_____

Revocation of this Consent

I revoke consent for your use and disclosure of my protected health information for treatment, payment, and healthcare operations.

Signature_____Date_____