

CHART # _____

Consent for the Use or Disclosure of Protected Health Information

As required by the Health Insurance Portability and Accountability Act of 1996, this practice may use your health information for the purposes of treatment, payment, or health care operations. The specific uses and disclosures that we intend to make are described in our Notice of Information Practices. You have the right to review the Notice of Information Practices prior to signing this consent form. You may request restrictions on the uses and disclosures described in the Notice of Information Practices by describing the restrictions in the “restriction request” section of this form. You may revoke this consent at any time by signing and dating the revocation section on your copy of the form and returning it to this office.

CONSENT SECTION:

I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and health care operations. My signature below indicates that I have been given an opportunity to read the Notice of Information Practices and to have any questions answered before signing.

I understand that I may request restrictions on the uses and disclosures of my health information at any time by completing and signing the restriction request section of this form. I further understand that the practice is not required to accept my restriction request.

I understand that I may revoke this consent at any time by signing the revocation section of my copy of this form and returning it to this practice. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this consent.

May we leave information regarding your diagnosis, treatment, and follow-up on your home answering machine? YES NO

May we leave information regarding your diagnosis, treatment, and follow-up on your work answering machine? YES NO

May we communicate information regarding your diagnosis and treatment through email? YES NO

May we call you with an automated system to remind you of your appointment? YES NO

RESTRICTION REQUEST SECTION:

I hereby request the following restrictions on the uses and disclosures of my health information (please describe the requested restrictions in detail):

Patient's Signature

Today's Date