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Consent for purposes of Treatment, Payment and Healthcare Operations

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I consent to the use or disclosure of my protected health information for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care. I understand that diagnosis or treatment of me may be conditioned upon my consent as evidence by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The above organization is not required to agree to the restrictions that I may request. However, if the above organization agrees to a restriction that I request, the restriction is binding on the above organization.

I have the right to revoke this consent, in writing, at any time, except to the extent that the above organization has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review the above organizations Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bill or in the performance of health care operations of the above organization. The Notice of Privacy Practices is also provided at the above organization and on the website it applicable. This Notice of Privacy Practices also describes my rights and the above names organization's duties with respect to my protected health information.

The above named organization reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Name of Patient or Personal Representative Signature of Patient or Personal Representative

_____ _____

Date Description of Personal Representative's Authority

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this form, but was unable to do so as documented below:

Date:	Initials:	Reason: