ACKNOWLEDGMENT OF RECEIPT AND CONSENT FOR USE / DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____

DOB: _____

Notice to Patient:
By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of **treatment**, various activities associated with **payment** and **health care operations**. Our **Notice of Privacy Practices** provides more details on our treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

As stated in our **Notice of Privacy Practices**, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to your health care information, you have a right to receive a copy by contacting our Privacy Officer.

You have the right to **revoke** your Consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You should also understand that if you revoke this Consent we may decline to treat you.

You are entitled to a copy of this **Consent Form** after you have signed it.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge I have been given the opportunity to receive and/or read the Notice of Privacy Practices. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment activities and health care operations to:

_____(recipient) _____(relationship to patient)

_____(recipient) _____(relationship to patient)

_____(recipient) _____(relationship to patient)

_____ _____
Patient's Signature or Signature of Patient's Representative Date

_____ _____
Printed Name of Patient's Representative Relationship to Patient

This authorization will <u>expire one year</u> from the date signed by patient or representative.