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CONSENT FOR DISCLOSURE OF HEALTH CARE INFORMATION

Patients Name_____ Date of Birth_____

S.S.#_____ Doctor's Name _____

My personal health information is private and confidential. I understand that my doctor and his staff work very hard to protect my privacy and preserve the confidentiality of my personal health information.

I understand that my doctor and his staff may use and disclose my personal health information to help provide health care to me, and to handle billing and payment , and to take care of other health care operations. There will be no other uses and disclosures of this information unless I permit it. However, I understand that sometimes the law may require the release of this information without my permission.

I can ask my doctor to limit how my personal health information is used or disclosed to carry out treatment, payment or health care operations. I understand that my doctor does not have to agree to my request, I understand that my doctor and his staff would follow the agreed upon limits.

I may cancel this request at any time by doing the following:

1. Signing and dating a form that my doctor or his staff can give me called "Revocation of Consent for Use and Disclosure of Health Care Information"
2. Writing, signing and dating a letter to my doctor directly. If I write a letter, it must say that I want to cancel my consent to authorize the use and disclosure of my personal health information for treatment, payment and healthcare options.

If I cancel this consent, my doctor and his staff do not have to provide any further health care services to me.

My doctor has a detailed document called the "Notice of Privacy Practices." It contains more information about the policies and practices protection of my privacy. I have the right to read the "Notice" before signing this agreement. My doctor may update this "Notice". If l ask the doctor or his staff will provide me with the most current "Notice" and will always have it available at my doctor's office

My signature below indicates that I have been given the chance to review a current copy of my doctor's "Notice of Privacy Practices." My signature means that I agree to allow my doctor to use and disclose my personal health information to carry out treatment, payment and healthcare operation.

Patient or Legal Guardian_____

Relationship to Patient _____ Today's Date _____

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