
# PATIENT CONSENT
# FOR
# USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____
Address: _____
Telephone: _____ Email: _____

HIPAA requires that we obtain your consent to use and disclose your protected health information for the purposes of carrying out treatment, obtaining payments, and carrying on healthcare operations for your care.

By signing this consent form you will have acknowledged that you have read our Notice of Privacy Practices.

You have the right to revoke this Consent by submitting your revocation to us in writing. Any action we took prior to your revocation will not be affected. We may choose to discontinue your treatment if you revoke your consent for us to use and disclose your health information for the reasons stated above.

I, _____, (print your name here) have read the Notice of Privacy Practices and consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

Personal Representative's Name: _____
Relationship to Patient: _____

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT**