PROTECTED HEALTH INFORMATION DISCLOSURE CONSENT

NOTICE OF PRIVACY PRACTICES
Review our Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may choose to review the Notice prior to signing this consent. By signing below, you acknowledge that we have given you a copy of our Notice of Privacy Practices.

USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION
Your Protected Health Information will be used by our practice or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

REQUESTING A RESTRICTION ON THE USE OR DISCLOSURE OF YOUR INFORMATION
You may request a restriction on the use or disclosure of your Protected Health Information. Our office may or may not agree to restrict the use or disclosure of your Protected Health Information. If we agree to your request, the restriction will be binding with our office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of Federal privacy standards.

REVOCATION OF CONSENT
You may revoke this consent to the use and disclosure of your Protected Health Information. However, you must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature

Date_____ Time_____

Print Patient's Full Name _____

Witness Signature

Date_____ Time_____