



CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice is available upon request.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Statement of Privacy Policy: We are committed to protecting medical information. The details of our Privacy Policy will tell you about the ways in which we may use and disclose information about you/your dependent. The notice also describes your rights and outlines obligations we have regarding the use and disclosure of your information. We are required by law to make sure the medical information we have that identifies you is kept private. We are also required by law to give you a copy of our notice of legal duties and privacy practices, and to follow the terms of the notice that is currently in effect. The notice of our Privacy Policy can be obtained upon request.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting the Privacy Officer at our office.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us a written notice of your revocation submitted to the Privacy Officer at our office. Please understand that revocation of this consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE-I have had the full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Patient Name: _____ **Date:** _____

Parent/Legal Guardian Signature: _____ **Relation to Patient:** _____