Notice of Privacy Practices

I give this practitioner the consent to use or disclose my personal health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations such as quality reviews.

I have been informed that I may review the practitioners Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practitioner has the right to change their privacy practices and that I may obtain any revised notices of the practitioner.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practitioner is not required to agree to the request. If the practitioner agrees to the request restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for the information already used or disclosed.

_______________________________________ ____________________

Patient, Parent or Legal Guardian Signature Date

If signed by patient representative, state relationship to patient; ____________________________