CONSENT FOR USE AND DISCLOSURE OF YOUR HEALTH INFORMATION

Our purpose in asking you to sign this form is to document that we have informed you that this office may use and disclose all your health information in our possession (collectively "Protected Health Information").

The uses and disclosures by this office of your Protected Health Information are necessary and will be used by this office in connection with your treatment, our obtaining payment for treatment and services that this office provides to you and so that this office can conduct its health care operations.

For a more complete description of how this office may use or disclose your Protected Health Information, please carefully review the Notice of Privacy Practices Form that this office has prepared and is furnishing to you today. Please also see our Notice of Privacy Practices Form for a more detailed discussion of the meanings of "treatment", "Payment" and "Health care operations".

YOU HAVE THE RIGHT TO REVIEW OUR NOTICE OF PRIVACY PRACTICES FORM PRIOR TO SIGNING THIS CONSENT. PLEASE BE ADVISED THAT THE NOTICE OF PRIVACY PRACTICES FORM MAY BE REVISED BY THIS OFFICE FROM TIME TO TIME. ANY SUCH REVISED NOTICE OF PRIVACY PRACTICES FROM WILL BE MADE AVAILABLE TO YOU BY CONTACTING. YOUR PHYSICIAN.

YOU SHOULD ALSO REVIEW CAREFULLY THE NOTICE OF PRIVACY PRACTICES FORM BECAUSE IT CONTAINS A LIST OF RIGHTS THAT ARE AVAILABLE TO YOU WITH RESPECT TO THIS OFFICE'S USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION. THESE RIGHTS INCLUDE YOUR RIGHT TO REQUEST RESTRICTIONS ON OUR USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION.

YOU HAVE THE RIGHT TO REVOKE THIS CONSENT AT ANY TIME. IF YOU WISH TO REVOKE THIS CONSENT YOU MUST DO SO IN WRITING.

BE SIGNING BELOW, YOU ACKNOWLEDGE THAT YOU HAVE READ, AND UNDERSTAND THI CONSENT AND THIS OFFICE'S NOTICE OF PRIVACY PRACTICES FORM. YOU FURTHE ACKNOWLEDGE THAT YOU HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVAC PRACTICES FROM TO TAKE WITH YOU.

_____ _____

Witness Date

_____ _____

Patient Signature Date

AUTHORIZATION FOR THE USE OR DISCLOSURE OF YOUR HEALTH INFORMATION.

By signing below, I hereby authorize my health information, as more specifically described as follows:

_____ (the "Protected Health Information"), to be used or disclosed for the following purposes: _____.

[If the use or disclosure is at the patient's request, insert "At the Patient's Request instead of a specific purpose.]

The specific person or class of persons who are authorized to use or disclose my Protected Health Information are:

_____

_____

The person or class of persons to whom this office may use or disclose my Protected Health Information are:

_____

This Authorization shall expire on:

I understand that I have the right to revoke this Authorization, if the revocation is on writing , except of

- This office has taken action in reliance upon this Authorization; or
- This Authorization was given as a condition of obtaining insurance coverage and the insurance company has the right to contest a claim made under the insurance policy.

I understand that I may revoke this Authorization by delivering written notice to

_____

I understand that my Protected Health Information that is used or disclosed pursuant to this Authorization may be subject to re-disclosure by the person(s) you have disclosed it to, and the privacy of my Protected Health Information will no longer be protected.

I acknowledge that I have read and understand this Authorization. I authorize the use of disclosure of my Protected Health Information in accordance with the terms of this Authorization.

_____ _____

Witness Date

_____ _____

Patient Signature or Authorized Representative Signature Date

Description of authorized Representative's authority to sign for the patient:

_____