CONSENT FOR DISCLOSURE OF HEALTH INFORMATION

Patient' s Name: -

_____

Patient's Date of Birth: _____

Patient's SSN:

_____

Notice to Patient:
By signing this form, you grant us consent to disclose your protected health care information to the individual(s) listed below. Our **Notice of Privacy Practices** provides more details on uses and disclosures of your protected health information for treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

You have the right to **revoke** your Consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You are entitled to a copy of this **Consent Form** after you have signed it.

(To Be Completed by Patient or Patient's Representative)

I, _____, have read the contents of this Consent Form and the Notice of Privacy Practices. I understand that I am giving you my consent to disclose my health care information with the person or persons listed below.

_____

_____

_____

_____

_____ _____
Patient's Signature or Signature of Patient's Representative Date

_____ _____
Printed Name of Patient's Representative Relationship to Patient

FOR OFFICE USE ONLY:

Name of Practice _____

Privacy Officer's Signature or Practice Representative _____

Date _____