CONSENT

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations such as quality reviews from said insurance companies.

I have been informed that I may review the practice/clinic's Notice of Privacy Practices (for more complete description of uses and disclosures) before signing this consent.

I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic.

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 practice/clinic is not required to agree to the request. If the practice/clinic agrees to the requested restriction, they must follow the restrictions.

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

Signature: _____ Date: _____

If signed by patient representative, state relationship to patient: _____