Privacy Practice

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 healthcare operations like quality reviews.

I have been informed that I may review the practice/clinic's Notice of Privacy Practices for a 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 a right to request a restriction n 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 my requested 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 information already used or disclosed.

May we discuss your medical record with any family member or friend? YES or NO
If YES, please list the persons below

Name:_____Ph:_____
Name:_____Ph:_____
Name:_____Ph:_____

Patient Name:_____

Signature:_____ Date:_____

If signed by patient representative, state relationship to patient_____

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