Consent for use and disclosure of Health Information

Section A: Patient consent

Name_________________________

Address______________________________Telephone__________________________

Social security#______________________________

Section B: I consent to the use and disclosure of my protected health information to carry out treatment, payment and healthcare operations. You have the right to read the Notice of Privacy Practices before you sign this consent. We encourage you to read it prior to signing this form. I understand that I have the right to revoke this consent at any time by giving a written notice to the office. The revocation will only apply to any further actions or treatment performed by the office from that point onwards.

Signature__________________________ Date____________________

If you are signing on behalf of a patient please complete the following

Name__________________________________ Relation to the patient______________________

Revocation of consent

I revoke my consent for use and disclosure of my protected health information for treatment, payment and healthcare operations

Signature___________________________________Date______________________________

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