Consent for Use and Disclosure of Personal Health Information

This form authorizes us to use and disclose your protected health information (PHI) for the purposes of healthcare operations, treatment and payment activities. Before Signing, please read our *Privacy Policy* to gain a clear understanding of how we may use and disclose your PHI. For questions concerning our privacy policy, please feel free to call or email us.

Patient's Consent:

Name: ______________________________ Address: ______________________________

Telephone: ____________________________ ______________________________

I have read your *Privacy Policy* and I consent to your use of my PHI for the purpose of healthcare operations, treatment and payment activities.

____ ____________________

Patient's Signature (or authorized guardian) Date

If signed by an authorized guardian or representative, complete the following:

Relationship to Patient: ______________________________

Telephone/Contact: ____________________

Patient's Revocation:

By signing below, you revoke your above consent for us to use and disclose your PHI. By doing so, we reserve the right to discontinue treatment for you. This revocation does not negate any of our prior actions while acting under your consent.

____ ____________________

Patient's Signature (or authorized guardian) Date

If signed by an authorized guardian or representative, complete the following:

Relationship to Patient: ______________________________

Telephone/Contact: ____________________