Consent for Disclosure of Healthcare Information

Patient's Name _____ Date of Birth _____

My personal health information is private and confidential. I understand that my doctor and his staff work very hard to protect my privacy and preserve the confidentiality of my personal health information.

I understand that my doctor and his staff may use and disclose my personal health information to help provide healthcare to operations. There will be no other uses and disclosures of this information unless I permit it. However, I understand that sometimes the law may require the release of this information without my permission.

I can ask my doctor to limit how my personal health information is used or disclosed to carry out treatment, payment, or healthcare operations. I understand that my doctor may deny my request. If my doctor does agree to my request, I understand that my doctor and his staff would follow the agreed limits.

I may cancel this consent at any time by doing the following:

1) Signing and dating a written request to your doctor specifying what information you wish to restrict and to whom the restriction applies. You will receive a written response to your request.
2) Writing, signing and dating a letter to my doctor directly. If I write a letter, it must say that I want to cancel my consent to authorize the use and disclosure of my personal health information for treatment, payment, and healthcare operations.

If I cancel this consent, my doctor and his staff do not have to provide any further healthcare services to me.

My doctor has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protection my privacy. I understand that I have the right to read the "Notice" before signing this agreement. My doctor may update this "Notice".

If I ask, my doctor or his staff will provide me with the most current "Notice" and the current "Notice" will always be available at my doctor's office.

My signature below indicates that I have been given the chance to review a current copy of my doctor's "Notice of Privacy Practices". My signature means that I agree to allow my doctor to use and disclose my personal health information to carry out treatment, payment, and healthcare operations.

_____ _____

PATIENT (OR LEGALLY AUTHORIZED INDIVIDUAL) SIGNATURE DATE

_____

RELATIONSHIP TO PATIENT