Notice of Privacy Practices
Consent to Use and Disclose and Receipt of Privacy Notice

Section A: Individual Giving Consent

Patient Name: _____Date of Birth: _____

Guardian of Patient: _____ Relationship: _____

Section B: To the Individual-Please Read the Following Statements Carefully

Purpose of Consent: By signing this form, yow will consent to the use and disclosure of your medical records to carry out treatment, payment and health care operations as discussed in our Privacy Practice Notice. This consent is in effect until revoked by you.

Effect of Declining Consent: This consent is a condition of your treatment by us. If you decide not to sigh this consent, we may decline to provide treatment to you.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of uses and disclosures we may make from your protected health information for treatment, payment, and health care operations as well as other important matters about your protected health information. A copy of our Notice accompanies this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. If changes occur, they may apply to any of your protected health information that we maintain.

Right to Revoke: You have the right to revoke this consent at any time by giving us written notice of your revocation. Please note that the revocation of this consent will *not* affect any action we took in reliance on this consent before we received your written notice of revocation. We may decline to treat you if you revoke this consent.

Signature:

I have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that by signing this consent form I am giving consent to your use and disclosure of my protected health information to carry out treatment, payment, and health care operations. **I acknowledge that I have received a copy of the Notice of Privacy Practices.**

_____ _____

Signature of Patient or Person Responsible for Patient Date

Explain reason for not signing: _____