CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: CONSENT

Name: _____

Address: _____

Telephone: _____ Email: _____

Social Security if age 18 and older: _____/_____/_____

SECTION B:

Purpose of the consent: By signing this form, you will consent to our use and disclosure of your protected health insurance information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Policy: 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 our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is available on our website and is available at any time. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy policy as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Private Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to Dr Sokolosky. Please understand that revocation of the Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating 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 Policy on your website. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Initials: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative Name: _____

Relationship to the Patient: _____