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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT GIVING CONSENT

Name:
Address:

List individuals who you would like involved in your care.
By writing their names on this form, you consent to the release of your health information to them.

_____

_____

Purpose of Consent:

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

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 the Contact Person listed above.

CONSENT I have had full opportunity to read and consider the contents of this consent form. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information.

Signature:_____/Date:_____ Printed Name:_____

If this Consent is signed by a personal representative / guardian on behalf of the patient, complete the following: Personal Representative's Name: _____ Date:_____
Relationship to Patient_____

PATIENT RIGHTS Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so.