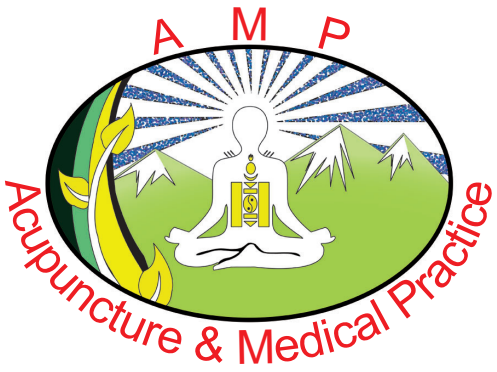

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ Email: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

In the course of providing service to you, we create, receive, and store health information that identifies you. It is sometimes necessary to use and disclose this health information in order to treat you, to obtain payment, and to conduct healthcare operations involving our office.

We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures, in detail. Please feel free to refer to this notice or to request a copy to this notice prior to signing this consent.

The use and disclosure of your health information for **treatment purposes** not only to includes care and services provided here, but also disclosures as may be necessary or appreciate for you to receive follow up or emergency care from another health professional.

The use and disclosure of your health information for **payment purposes** includes our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; our submission of claims to third-party payers or insurers for claims review, determination for benefits, and payment; and our submission of your health information to auditors hired by third-party payers and insurers.

The use and disclosure of your health information for **healthcare operations** includes quality assessment and improvement activities as well as evaluating practitioners and conducting training programs. A complete list is provided in our Notice of Privacy Practices.

Our Notice of Privacy Practices will be updated if our policies change. You may get an updated copy here at our office.

You can revoke this consent in writing at any time unless we have already treated you, sought payment for services, or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent.

We can decline to serve you if you elect not to sign this consent form.

Signing this consent signifies that you have been given the opportunity to read our Notice or Privacy Practices and/or given a copy of it if you desire one.

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS.

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____