CONSENT TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

Federal regulations (HIPAA) allow me to use or disclose Protected Health Information (PHI) from your record in order to provide Treatment to you, to obtain Payment for the services we provide, and for health care Operations (TPO) or other professional services warranted in your treatment. I ask your consent in order to make this permission explicit. The *Notice of Privacy Practices* describe these disclosures in more detail. You have the right to review the *Notice of Privacy Practices* before signing this consent.

We reserve the right to revise our *Notice of Privacy Practices* at any time. If we do so, the revised version will be posted in the office. You may ask for a printed copy of the revised *Notice of Privacy Practices* at any time.

You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment, or health care operations. However, we do not have to agree to these restrictions. If we do agree to a restriction, that agreement is binding.

You may revoke this consent at any time by giving a written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation.

This consent is voluntary. You may refuse to sign it. However, we are permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked.

I hereby consent to the use or disclosure of my Protected Health Information (PHI) for Treatment, Payment, and Health Care Operations (TPO).

_____
Patient's Signature

_____
Patient's Printed Name

Date _____

_____
Parent's Signature (If patient is under 18)

_____
Parent's Printed Name

_____
Date

_____
Parent's Signature (If patient is under 18)

_____
Parent's Printed Name

_____
Date