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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I understand that I have certain rights to privacy regarding my protected health information under the Health Insurance Portability and Accountability Act (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out our 1) treatment (including direct or indirect treatment by other healthcare providers involved in my treatment); 2) obtaining payment from third party payers (e.g. my insurance company); and the day-to-day healthcare operations of this practice.

I have also been informed of, and given the right to review and secure a copy of this practice's Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I have the right to contact you to obtain the most current copy of this notice at any time.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent, is not affected.

Signed this_____ day of_____,20_____.

Print Patient name:_____.

Relationship to Patient:_____.

Signature:_____.

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained.

_____Individual refused to sign

_____Communications carriers prohibited obtaining the acknowledgement.