CONSENT FOR USE OF PERSONAL HEALTH INFORMATION AND NOTICE OF PRIVACY PRACTICES

Please initial next to the appropriate lines.

_____ I received the Notice of Privacy Practices information.

_____ I **authorize** use of my personal health information as necessary for treatment, payment, and other healthcare operations. This does include release of information to another provider for continuation of care.

_____ I **refuse** consent for use of my personal health information as necessary for treatment, payment, and other healthcare operations. This does include release of information to another provider for continuation of care.

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 Office Manager. Please understand that revocation of this 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.

Patient/Parent/Guardian Signature: _____

Patient Name (printed): _____

Date: _____

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