CONSENT FOR DISCLOSURE AND ACKNOWLEDGEMENT OF NOTICE

Patient: ______________________________

Please read the following statements carefully:

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.*

Notice of Privacy Practices: *You have the right to read our Notice of Privacy Practices. We encourage you to read it carefully and completely before signing this Consent.*

Right to Revoke: *You will have the right to revoke this Consent at any time by giving us written notice of your revocation. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we receive your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.*

** I have had full opportunity to read and consider this Consent form and the Notice of Privacy Practices. I understand that, by signing this Consent, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.*

Print Name: ____________________________
Patient/Parent Signature: ____________________________
Relationship to Patient: ____________________________

{You are entitled to a copy of this Consent after you sign it}
{You may refuse to sign this}