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Patient Consent Form

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.

I have been informed by your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review the *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain the current *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict the use of my private information for uses or disclosures to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name _____

Signature _____

Date _____

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