

**PATIENT CONSENT  
FOR  
USE AND DISCLOSURE OF HEALTH INFORMATION**

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_

HIPAA requires that we obtain your consent to use and disclose your protected health information for the purposes of carrying out treatment, obtaining payments, and carrying on healthcare operations for your care.

By signing this consent form you will have acknowledged that you have read our Notice of Privacy Practices.

You have the right to revoke this Consent by submitting your revocation to us in writing. Any action we took prior to your revocation will not be affected. We may choose to discontinue your treatment if you revoke your consent for us to use and disclose your health information for the reasons stated above.

I, \_\_\_\_\_, (print your name here) have read the Notice of Privacy Practices and consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.**

**REVOCAION OF CONSENT**

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that any action you took prior to my revocation will not be affected. As a result of my revocation, you may elect to discontinue treating me.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

This document is not a substitution for legal advice.