Health Care Provider Consent Form

Purpose: The purpose of this form is to obtain an individual's consent to our use and disclosure of the individual's protected health information to carry out treatment, payment activities, and health care operations.

SECTION A: Individual giving consent.

Name: ____

Address: ____

Telephone Number: __________________________ E-mail: ________________________

Social Security Number: _______________________

SECTION B: To the individual — 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 health care operations.

Effect of Declining Consent: This consent is a condition of your treatment by us. If you decide not to sign this consent, we may decline to treat you.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices containing the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office

Restriction Requests: You have the right to request that we restrict how we may use or disclose your protected health information to carry out treatment, payment activities, and health care operations. We are *not* obligated to agree to these restrictions. If we elect to agree, we will be bound only by the restrictions to which we agree.

OVER ⟶

Please tell us if you want to request restrictions. [We will provide you with our Restriction Request Form for you to describe the restrictions you want and for us to consider and decide if we will agree to them.] We will indicate whether we accept or decline your restrictions and notify you of our decision in due course.

You may withhold signing this consent until you have our decision on your request for restrictions, or you may revoke this consent if we decline to agree with your request for restrictions. Please understand that we may decline to treat you until we have this consent, and we may decline to treat you or to continue treating you if you revoke 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 submitted to the Contact Office listed above. [We may ask you to complete our Consent Revocation Form to ensure that we have accurate information regarding your decision to revoke this consent.]

Please understand that revocation of this consent will *not* affect any action we took in reliance on this consent before we received your written notice of revocation and that we may decline to treat you or to continue treating you if you revoke this consent.

SIGNATURE.

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

Signature: ____ Date: ______________________

If this consent is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: ____

Relationship to Individual: ____

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