CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

TO THE 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 before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely.

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, which will contain 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.

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 received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Messages: Our office will sometimes call to confirm or reschedule appointments. We need your consent to leave messages for these reasons or when returning calls you have made to us. If you would like us to leave messages, please initial each location where these messages can be left: Home _____ Work _____ E-mail _____

Postcards: We will sometimes send postcards to remind you of upcoming or missed appointments. Please verify that you would like to receive these postcards by placing your initials here: _____

Use of Records: Dr. Freedman occasionally uses patient records for educational purposes. Personal information is protected at these times. Please verify that your or your child's records can be used by placing your initials here: _____

Postings: We occasionally post patient photos or artwork in our office. Please verify that we can post your or your child's photos and artwork by placing your initials here: _____

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 heath care operations.

Signature: _____ Date: _____

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

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT
Include completed Consent in the patient's chart

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