

## Consent Form

I give this practice / clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my request restrictions, they must follow restriction (s).

I also understand that I may revoke this consent at anytime, by making a request in writing, except for information already used or disclosed.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(patient, parent or legal guardian)

\_\_\_\_\_  
(print name) (relationship to patient, if signed by representative)