Consent for Disclosure of Health Information

Section A: Patient Giving Consent

NAME: ______________________________

ADDRESS: ______________________________

TELEPHONE: ______________________________

SOCIAL SECURITY NUMBER: ______________________________

Section B: To the patient- Please read the following statement 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 the 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 other important matters about your protected health information. You may request a copy of our notice. 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. 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.

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 office of Dr. Keith Nowicki. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received our 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 the contents of this consent form and notice of privacy practices, I understand that by signing this consent form, I am giving my consent to use and disclose my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: ____________________ Date: ____________________

If a personal representative on behalf of the patient signs the following consent, complete the following:

Personal Representative's Name: ______________________________

Relationship to patient: ______________________________