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1428 W. Hebron Pkwy | Ste 140 • Carrollton, TX 75010 (972)394-1234


CONSENT FOR USE AND DISCLOSURE OR HEALTH INFORMATION

**Patient Name:** _____ _____ ___ _____

Last First MI Preferred Name

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. By signing this form, you acknowledge that we provided you access to a copy of our privacy notice.

**By signing, I certify that 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 healthcare operations. Furthermore, I give my consent to discuss (as deemed necessary) my protected health information with my**

☐ Spouse ☐ Parent ☐ Friend ☐ Child ☐ Sibling

**If Consent is signed by a legal guardian or personal representative on behalf of the patient, please list:

Name: _____ Relationship to Patient: _____

Signature _____ **Date** _____

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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. 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, 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:

ELAINE CALVERT - General Manager

Phone: 972-394-1234 Fax: 972-394-1154

Address: 1428 W. Hebron Pkwy #140, Carrollton, TX 75010

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 this Contact Person listed above. 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.

By signing below, I certify that I chose to REVOKE MY CONSENT for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that you may decline to treat me after I have revoked my Consent.

Signature _____ **Date** _____

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**Response Date:** _____