Patient Consent for Use and Disclosure of Protected Health Information

Patient Name ________________________________ Date _______________

With my consent, Valerie G. Davis, M .D. may use and disclose protected health information about me to carry out treatment, payment, and healthcare operations. Please refer to the Notice of Privacy for a more complete description of such uses and disclosures. I have the right to review the Privacy Notice prior to signing this consent; it is available at the front desk. The practice reserves the right to revise the Privacy Notice at any time.

With my consent, Valerie G. Davis, M .D. and/or her staff may send mail to my home or other designated location(s) that assist the practice in carrying out treatment, payment, and other healthcare operations.

I have the right to request that Valerie G. Davis, M.D. restrict how she uses or discloses my protected health information and to carry out my treatment, payment, and healthcare operations. Please note, the practice is not required to agree to my requested restriction, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Valerie G. Davis, M .D. the use and disclosure of my protected health information and to carry out my treatment, payment, and healthcare operations.

I may revoke my consent in writing except to the extent the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Valerie G. Davis, M.D. may decline to provide treatment to me.

You have the right to choose to whom we may release your protected health information. Please check and initial next to those persons to whom you wish your protected health information be released to.

All family members (Initials) ______

Spouse only (Initials) ______

Other (Please list name and contact number) ______________________________

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____ (Initials) ______

Signature of patient and/or legal guardian: _____________________________________

If legal guardian, please print name: ____