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SUMMARY NOTICE OF PRIVACY PRACTICES
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. 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.

We are required by federal and state law to maintain the privacy of your health information. We are also required to provide you notice about our privacy practices, our legal duties, and your rights concerning your health information. You have the right to read our Notice of Privacy Practices before you decided whether to sign this Consent. We reserve the right to change our privacy practices and the terms at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes.

You may request a copy of our Notice at any time. For more information about our privacy practices or for additional copies of our Notice of Privacy Practices, please contact us as shown above.

You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact as shown 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.

I have had the 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 health care operations. I also understand that this office and any third party used for treatment, billing, collection and other services, may use any means of communication with you.

_____
Printed Name of Patient

_____ _____
Signature of Patient or Parent, Guardian or Personal Representative Date