Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and plan for future care or treatment. I understand that this information may be disclosed for treatment, payment or health care operations.

Acknowledgment of Receipt of Notice of Privacy Practices

I have been provided with a Notice of Privacy Practices that gives a more complete description of information uses and disclosures. I understand that I Have the right to review the notice prior to signing this consent. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restriction requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

X _____

Patients Name Chat Number Account

X _____

Signature of Patient or Legal Representative Witness

X _____

Date Notice Eff. Date

Request the following restrictions to the user of disclosure of my health information

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