Consent for Use and Disclosure of Health Information

Section A: Patient Giving Consent

Name: _____

Address: _____

Telephone: _____

Section B: To the Patient

By signing this form, you are giving consent to our use and disclosure of your protected health information to carry out treatment, payment activties, and healthcare operations in accordance to our policy of privacy practices, which has been made available to you.

Signature: _____

Date: _____