CONSENT FOR USE AND DISCLOSURE OF YOUR HEALTH INFORMATION

Our purpose in asking you to sign this form is to document that we have informed you that this office may use and disclose your health information in our possession.

The use and disclosure by this office are necessary and will be used in connection with your treatment, our obtaining payment for treatment and services that this office provides to you, and so that this office can conduct its health operations.

For a more complete description of how this office may use or disclose your Protected Health Information, please review the Notice of Privacy Practices Form that this office has prepared and is furnishing for you. Please also see our Notice of Privacy Practice Form for a detailed discussion of the meanings of “treatment”, “payment", and “health care operations".

You have the right to review our Notice of Privacy Practices Form prior to signing this consent. Please be advised that the Notice of Privacy Practices Form may be revised by this office from time to time. Such revisions of the Notice Of privacy Practice Form will be made available to you by contacting Mary Ann Shaieb.

You should also review carefully the Notice of Privacy Practices Form because it contains a list of rights that are available to you with respect to this office's use and disclosure of your projected health information. These rights include your right to request restrictions on our use or disclosure of your protected health information.

You have the right to revoke this consent at any time. If you wish to revoke this consent, you may do so in writing.

By signing below, you acknowledge that you have read and understand this consent and this office's Noticed of Privacy Practiced Form. You further acknowledge that you have received a copy of this office's Notice of Privacy Practices Form to take with you.

_____ _____

Patient Signature Date Signed by Patient

_____ _____

Witness Date Signed by Witness