PATIENT CONSENT

I have received the PATIENT INFORMATION AND OFFICE POLICY STATEMENT, and the HIPPA NOTICE OF PRIVACY POLICIES AND PRACTICES. I understand that by signing this form I consent to the following:

a) Sharing information for purposes of treatment: *The office will share my information with all members of my treatment team in order to provide me with quality care.*

b) Sharing of information for purposes of payment: *The office will share all necessary information involved in the billing and payment of my medical services. This includes, but is not limited to my insurance company and their representatives, my providers billing service, and the claims clearinghouses which they use.*

c) Sharing of information for purposes of operation: *The office will share all information necessary for the ongoing operations of the office. This includes, but is not limited to, credentialing, accreditation, and compliance with federal and state laws.*

My consent is freely given. I understand that I may revoke this consent at any time, if the revocation is in writing. I also understand that any disclosures given in reliance of this prior consent will be permissible.

_____ _____

Patient's Name (printed) *Date*

_____

Patient's Signature (or Guardian)