CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

You May Refuse to Sign This Acknowlegment.

I have received a copy of this office's Notice of Privacy Practices.

Print Name: _____

Relation to Patient: _____

Signature: _____ Date: _____

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to our Privacy Official. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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