

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Giving Consent:

Name: _____

Address: _____

Telephone: _____

Patient: Please read the following statements carefully:

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, healthcare operations, and other uses disclosed in our "Notice of Privacy Practices".

Notice of Privacy Practices:

You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, and other uses and disclosures we may make of your protected health information, and other important matters about your protected health information. A copy of our Notice is provided here with. We encourage you to read it carefully and completely before signing the Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice which will contain the changes.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation.

I acknowledge receipt of Respiratory Consultants of Georgia "Notice of Privacy Practices" and have had the opportunity to read and consider the contents of this Consent form and Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

Signature of Patient or Legal Guardian: _____ Date: _____

Notice Effective Date or Version: _____

I authorize Respiratory Consultants of Georgia to mail reminder post cards to my home address:

()Yes ()No

I request the following restrictions to the use or disclosure of my health information:

