Consent for the Use or Disclosure of Protected Health Information

As required by the Health Information Portability and Accountability Act of 1996, Sellersburg Internal Medicine and Pediatrics may not use your personal health information for the purposes of treatment, payment or healthcare operations. The specific uses and disclosures that we intend to make are described in our Notice of Information Practices. You have the right to review the Notice of Information Practices prior to signing this consent form. You may request restrictions on the uses and disclosures described in the Notice of Information Practices by describing the requested restrictions in the restriction request section of this form. You may revoke this consent at any time by signing and dating the revocations section on your copy of the form and returning to this office.

CONSENT SECTION

I, ____, (PRINT NAME) hereby consent to the use and disclosure of my personal health information for the purpose of treatment, payment and healthcare operations. My signature below indicates that I have been given an opportunity to read Sellersburg Internal Medicine and Pediatrics Notice of Information Practices and to have any questions answered before signing.

I understand that I may request restrictions on the uses and disclosures of my health information at any time by completing and signing the restriction request section of this form. I further understand that Sellersburg Internal Medicine and Pediatrics is not required to accept my restriction request.

I understand that I may revoke this consent at any time by signing the revocations section of my copy of this form and returning it to Sellersburg Internal Medicine and Pediatrics. I further understand that any such revocation does not apply to the extent that persons authorized to use of disclose my health information have already acted in reliance on this consent.

____ ________________________

Signature Date