Consent for Use and Disclosure of Health Information

Section A: Patient Giving Consent.

Name: _____ Phone:____:____:_____ SSN: ____-____-_____
Address: _____
City:_____ State: _____ Zip: _____

Section B: To the 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, and health care operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decided whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practice as described in our Notice of Privacy Practice. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain your copy of our Notice of Privacy Practices, including any revisions of our notice, at any time by contacting:

Contact Person(s): Elaine Wisdom or Teddie Land
Telephone: (785)776-1771
Fax: (785) 539-3905
1629 Poyntz Avenue
Manhattan, Kansas 66502
ewisdom2thdr@gmail.com

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 the contact person listed above. 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.

I, _____ have had full opportunity to read and consider the contents of this Consent Form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent for your use and disclosure of my protected health information to carry out treatment payment, payment activities and health care operations.

Signature: _____ Date: _____
If this consent is signed by a person, representative, or a parent on behalf of the patient, please complete the following:
Personal Representative's Name: _____
Relationship to Patient: _____