CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PT INFORMATION

Name: ____

Address: ____

Telephone# ____________________ Social Security # ____________________

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 information to carry out treatment, payment activities and healthcare operations.

NOTICE OF PRIVACY PRACTICES: You have the right to read our Notice of Privacy Practices before you decide to sign this Consent. Our Notice provides a description of our treatment, payment activities, office regulations, and the uses and disclosures we may make of your protected health information. A copy of our Notice accompanies this Consent. We encourage that you read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. In this event we will issue a revised Notice which will contain changes to the policy. These changes may apply to any of your protected health information that we maintain in your records.

You may obtain a copy of our Notice of Privacy Practices, including any revisions at any time.

Contact Person: Dr. Vladimir Khantsis Telephone: (765) 301-9000
Address: 813 East Franklin Street, Suite A, Greencastle, IN 46135

RIGHT TO REVOKE: You will have the right to revoke this Consent at any time by providing written revocation submitted to the contact person listed above. Please understand that revocation of this consent will affect any action we took in reliance on this consent before we received your revocation and that we may not treat you, or continue treating you if you revoke this Consent.

Patient Signature:

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

Signature______________________________ Date: ____________________

IF THIS CONSENT IS SIGNED BY A PERSONAL REPRESENTATIVE ON BEHALF OF THE PATIENT, PLEASE COMPLETE THE FOLLOWING:

Personal Representative's Name:______________________ Date:______________

Relationship to Patient:______________________________________