

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

NAME: _____

ADDRESS: _____

TELEPHONE: _____

E-MAIL: _____

PATIENT #: _____ 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 health information to carry out treatment, payment activities, this may included finance charges and to disclose healthcare operations.

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, of the use and disclosure we may make of your protected health information, and of other important matters of your protected health information. A copy of our Notice accompanies this Consent. We encourage you to 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. 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 the we maintain.

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

Contact Person: Sonia Fonticiella

Telephone : (870) 236-6930

Fax: (870-) 239-8065

E-mail: fonticiellamedicalclinic@yahoo.com

Address: 1000 WEST KINGSHIGHWAY
Suite 12
PARAGOULD AR 72450

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.

SIGNATURE

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 to your use and disclosure of my protected health information to carry out treatment, payment activities and health information to carry out treatment, as well as payment activities and this may included finance charges and health care operations.

Signature _____ Date _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Represenatives's Name _____

Relationship to Patient _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. Include completed Consent in patient chart

