

EVANS MEDICAL GROUP

CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PAYMENT, TREATMENT AND HEALTH CARE OPERATIONS

(To be signed and have on file yearly)

By signing below, you hereby consent for this Practice to use or disclose information about your self (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purpose of treatment, payment and health care operations. You may refuse to sign this consent form.

You should read the current Notice of Privacy Practices for PHI (posted at the front desk or may ask for a copy from the receptionist) before signing the Consent. The terms of the Notice may change from time to time, and you may always get a revised copy of it by asking the Privacy Officer for this Practice.

You have the right to request that the Practice restrict how PHI is used or disclosed to carry out treatment, payment, health care operations. The Practice is not required to agree to requested restrictions, however; if the Practice agrees to your requested restrictions, the restriction is binding on it.

Information about you is protected under federal law, and you have the right to revoke this Consent, unless we have taken action in reliance on your authorization (as determined by our Privacy Officer). By signing below, you recognize that the protected health information used or disclosed pursuant to this Consent may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

You may communicate with the following individuals (please list name, relationship and phone number) regarding my condition or course of treatment:

	Name	Relationship	Phone Number
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Individual Signature _____ Date _____

As a personal representative, I have authority
to act for the individual because I am the individual's

Patient name: _____