Consent for Disclosure of Health Information (To Third Parties)

Section A: Patient giving consent

Name: _____ DOB: _____ SSN: _____ Sex: _____

Street Address: _____ Home phone: _____

_____ Work phone: _____

E-mail address: _____ Cell phone: _____

Section B: To the patient - please read the following statements carefully

Purpose of consent: By signing this form, you are consenting to the use and disclosure of your protected health information to the assigned below person or persons below to carry out necessary treatment, payment activities and healthcare operations which includes other healthcare professionals directly related to your treatment and insurance companies.

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 Medical Records Department. Revocation of this Consent will not affect any action we have taken regarding this Consent before we received your revocation. Unless revoked, this document has no expiration.

Who is allowed access to information regarding your treatment or account status? This person must present themselves with two forms of identification.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Signature

I, _____, have read and considered the contents of this Consent form and I understand that, by signing this Consent form, I am giving my consent to you to disclose my or my child's protected health information to carry out treatment, payment activities, and healthcare operations.

Signature: _____ Date: _____

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

Representative's Name: _____ Relationship to Patient: _____

Revised: 12/31/2012
Approved: 12/31/2012