<u>Patient Consent for the Disclosure of Information</u>

I have read the **NOTICE OF PRIVACY PRACTICES** and have had any questions answered by this office. I understand that by signing this form I consent to the following:

- **<u>Sharing information for purposes of treatment:</u>** You will share my information with all members of my treatment team, both within this office and with other providers (personal and institutional) in order to provide me with quality care and the educational/wellness programs specified in my insurance plan.

- **<u>Sharing of information for purposes of payment:</u>** You will share all necessary information with my insurer(s), payor(s), governmental entities (such as medicare, medicaid, etc) and their representatives (including, but not limited to benefit determination and utilization review) as well as your representatives involved in the billing process (including, but not limited to claims representatives, data warehouses, and billing companies).

- **<u>Sharing of information for purposes of operations:</u>** You will share all information necessary for ongoing operations of this office, (including, but not limited to) the credentialing processes, peer review, accreditation and compliance with all federal and state laws.

My consent is freely given. I understand that I may revoke this consent at any time if that revocation is in writing, but any disclosures given in reliance on the prior consent will be permissible.

____________________________________ __________
Patient's Printed Name Date of Birth

____________________________________ __________
Patient's Signature (or guardian, if minor) date

____________________________________ __________
Witness (optional) date