CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

DR. KAREN HORTON

PLEASE READ CAREFULLY

This form authorizes Dr. Karen Horton to use and disclose your protected health information (PHI) for the purposes of healthcare operations, treatment and payment activities.

Before Signing please read our Notice of Privacy Practices to gain a clear understanding of how we may use and disclose your PHI. We reserve the right to change our privacy practices as described in out 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 that we maintain.

You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to PRIVACY OFFICIAL. 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 f you revoke this Consent.

PATIENT'S INFORMATION:

Name: _____.

Address: _____.

Phone: _____.

DURATION:

This authorization shall be effective immediately and remain in effect until _____.

PATIENT'S SIGNATURE:

☐ I, by signing this form, am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

☐ I, by signing this form, revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signed: _____ Date: _____

If not signed by the patient, please indicate relationship:
__ Parent or guardian of minor patient
__ Guardian or conservator of an incompetent patient
__ Beneficiary or personal representative of decrease patient

Name of Representative: _____

You are entitled to a copy of this signed consent.

Include completed form in the patient's chart.