Consent to Disclose Health Information

In the course of providing service to you, we are often asked about your condition and to disclose health information. The use and disclosure of your health information for treatment purposes not only includes care and services provided here, but also disclosures of this information as may be necessary or appropriate to arrange for you to receive follow-up care from another health professional.
The following area is provided so that you may list those persons who you have authorized to receive this information. When you sign this document, you signify that you agree that we can and will disclose your health information to those listed. You can revoke this consent in writing at anytime unless we have already treated you or performed tasks related to your care that relied upon our ability to use or disclose your health information in accordance with consent.

Name	**Relationship**
______________________________	______________________________
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I have read this consent and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment and healthcare operations.

Patient______________________________________ Date__________________

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form.

Relationship to Patient_____________________________

Printed Name_________________________________ Source of Authority________________________