

**CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
TO CARRY OUT TREATMENT, PAYMENT AND/OR HEALTH CARE OPERATIONS**

Through the use of the consent form Drs. Vance, Stovall and Buchanan (referred to as the or this “office”) is notifying you and you agree that:

1. Protected health information may be used and/or disclosed in order to carry out treatment, payment, or health care operations.
2. If you do not consent to the above use and/or disclosure, then this office will not treat you.
3. A notice containing the office’s privacy practice, including a more complete description of uses and/or disclosures necessary to carry out treatment, payment and/or health care operations, is available for you to read, and you are hereby encouraged to do so prior to signing this consent form.
4. This office reserves the right to change its privacy practices that are described in the above referenced notice, in accordance with applicable law, and will make available to all patients any and all revised and current notices.
5. You have a right to request that this office restrict how protected health information is used and/or disclosed to carry out treatment, payment and/or health operations.
6. This office is not required to agree to any restrictions that you have requested.
7. If this office agrees to a requested restriction, then the restriction is binding on the office.
8. You have a right to revoke this consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that this office has already taken action in reliance on this consent.
9. Should you revoke this consent at any time, the office retains the right to refuse treatment based upon the revocation and the future lack of such consent.
10. You will sign and date all consents requested to which you agree.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Individual (printed)

Signature of Individual

Signature of Legal Representative

Relationship

Date Signed _____ / _____ / _____

Witness