**Lakeview Medical Associates P.C.**
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# HIPPA WAIVER

With my consent, Lakeview Medical Associates, P.C. (hereinafter "Lakeview") may use and disclose protected health information about me to carry out treatment, payment and healthcare operations.

With my consent, Lakeview may call my home and other designated locations and leave a message on my voicemail or in person with reference to any item that assist the practice in carrying out treatment, payment, and healthcare operations, such as insurance items and any call pertaining to my clinical care, including laboratory results among others.

I have the right to request that Lakeview restrict how it uses or discloses my protected health information to carry out treatment, payments and healthcare operations. However, the practice is not required to agree with my request restrictions.

By signing the HIPPA document, I am consenting to Lakeview's use and disclosure of my protected health information to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign consent, Lakeview may decline to provide treatment for me.

Signature: ________________________________________________________

Date: ___________________________________________________________