Kresie & Penzler, M.D.'s PA

Consent to Use and Disclose of Protected Health Information for Purposes of Treatment, Payment, and Health Care Operations

As a condition of providing treatment to you, our office must obtain your consent to use and disclose **Protected Health Information** (further referred to as **PHI**) about you to carry out treatment, payment, and the health care operations of our office.

You may revoke this consent at any time by notifying our office in writing, except to the extent our office has taken action and reliance on your consent.

Your PHI may be used and disclosed to carry out treatment, payment or health care operations.

Please refer to the Notice of Privacy Practices for PHI (Privacy Notice) for a complete description of the uses and disclosures that our office/staff may use of your PHI. You have the right to review the Privacy Notice prior to signing the consent.

Our office has reserved the right to change its privacy practice described in this Privacy Notice. In accordance with the law, the terms of the Privacy Notice may change. At any time, you may obtain a copy of the current Privacy Notice and any revised notice by requesting the Privacy Notice in writing or by requesting a notice in person.

You have the right to request that our office restrict the manner in which your PHI is used or disclosed to carry out treatment, payment or health care operations. Our office is not required, however, to agree to such requested restrictions. If, however, our office agrees to the requested restriction, we will honor the request and it will be binding on the office.

I hereby consent to the use and disclosure by this office, its work force, and its business associates of my PHI for the purposes of treatment, payment, and health care operations.

I further give the office of Kresie & Penzler, M.D.'s PA the authorization to release any medical or financial information by mail or phone to ______________________________ regarding myself.

(A family member or friend)

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Signature Date

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Signature of personal Representative of Patient Date

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Description of Personal Representative of Patient