

Dr. Richard E Winnick & Associates

Consent for Use and Disclosure of Personal Health Information

This form authorizes us to use and disclose your protected health information (PHI) for the purpose of healthcare operations including – treatment, payment activities, insurance, recall notices, and confirming of appointments.

Before signing, please read our Notice of Privacy Policies to gain a clear understanding of how we may use and disclose your (PHI).

For questions concerning our Notice of Privacy Policies, please contact: Dr. Winnick & Associates.

Patient's Consent

Name: _____

Signature: _____

I, _____ have read your Notice of Privacy Policies and I consent to your use of my (PHI) for the purposes of healthcare operations including – treatment, payment activities, insurance, recall notices, and confirming of appointments.

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

Patient's Revocation

By signing below, you revoke your above consent for us and disclose your PHI. However, by doing so, we reserve the right to discontinue treatment for you. This revocation also does not negate any of our prior actions while acting under your consent.

Signature: _____ Date: _____

If this consent revocation is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

This information is intended as advisory in nature and should not be considered as legal advice nor is it a substitute for legal advice. This information does not constitute technical information system/security advice. It is designed to assist you in your own risk management activities. It is not intended to be exclusively relied upon or used as a substitute for your own loss-control program. Accuracy and completeness are not guaranteed.