

**GENERAL CONSENT TO USE AND DISCLOSURE
PROTECTED HEALTH INFORMATION**

This is a consent form. It asks you to permit us to use and disclose information about your health in keeping with both state and Federal law. This information is called “protected health information.” It is any information we receive or create that identifies (or could identify) you and deals with your physical or mental health, any health care we provide you and/or payment for such health care.

By signing this form, you are consenting to our use and disclosure of your protected health information in order to carry out treatment, payment or health care operations, as further explained in our “Notice of Privacy Practices” (the “Notice”).

By signing this form, you also acknowledge that you have received our Notice. This Notice describes in detail how we might use or disclose your protected health information. The Notice also discusses your rights and our duties with respect to your protected health information. You have the right to review the Notice before signing this consent.

Before releasing any information about your treatment for drug abuse, alcohol abuse or mental illness, and HIV or AIDS, other than as permitted or required by law, we will ask you to sign a separate consent form.

You also have the right to revoke this consent, in writing, except where we have previously taken action in reliance on your prior consent.

Signature of Patient or _____ Date _____
Legally Authorized Representative

Printed Name of Patient or _____ Legal Relationship _____
Legally Authorized Representative to Patient