CONSENT FOR USE/DISCLOSURE OF HEALTH INFORMATION

Patient's Name_____

Patient's Birth Date_____**Patient's SSN or ID #**_____

Notice to Patient
By signing this form, you grant us consent to use your protected health care information for the purpose of treatment, various activities associated with payment and health care operations. Our notice of Privacy Practices provides more details on our treatment, payment activities and health care operators. If there is not a copy of the Notice accompanying this consent form please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

As stated in our Notice of Privacy Practices, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to your health care information, you have the right to receive a copy by contacting our Privacy Officer.

You have the right to revoke your consent by giving written notice to our privacy officer. The revocation will not affect actions that were already taken in reliance of this consent. You should also understand that if you revoke this consent we may decline to treat you.

You are entitled to a copy of this consent form after you have signed it.

I, _____, have read the contents of this consent form and the notice of privacy practices. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment activities and health care options.

_____ _____
Patient's signature or patient representative **Date**

_____ _____
Printed Name of Patient's Representative **Relationship to patient**

Our privacy officer can be contacted as follows:
Name: Colleen
Address: 5676 Steubenville Pike McKees Rocks, Pa 15136
Phone: 412-787-1276 FAX: 412-787-7756