CONSENT FOR USE AND DISCLOSURE

OF HEALTH INFORMATION

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. If you decide not to sign this consent, we may decline to treatment for you.

Notice of Privacy Practices: You have the right to read out Notice of Privacy Practices before you decide whether to sign this consent. Out Notice provides a description of our treatment, payment activities, and healthcare operations., of the uses and disclosures we may make of your protected health information, and or other important matters about your protected health information.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us a written notice of your revocation submitted to the Office Manager. Please understand that revocation of the Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you if you revoke this Consent.

CONSENT:

I have had full opportunity to read and consider the contents of this Consent form. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

If you request a copy of your records, an additional $25 fee will be charged.

_____

Printed Name of Participant

_____

Signature of Participant Date

Dr. Alla Shikhanovich

_____

Doctor Signature

You are entitled to a copy of this consent after you sign it.

Dr. Alla Shikhanovich

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