

**Consent For Use and Disclosure of Medical Information
For Treatment, Payment and Health Care Operations**

I authorize the release of my health information regarding services rendered by the Practice to my insurance company or any governmental payer, or any other person/entities as may be reasonably necessary for billing and collection purposes. I also authorize the Practice to release medical information about me to other health care providers for treatment purposes. In addition, if the patient is a minor child, I as parent or guardian authorize the release of medical information to the person(s) that I have listed below as being responsible for the bill; I understand that this authorization to release information may include the release of personal and private medical information. If such a release of information is necessary for reimbursement and billing purposes, or for the purpose of subsequent treatment. Further, contained in hard copy or in electronic form, including, but not limited to electronic mail (“email”) and facsimile. Finally, I understand that the Practice may use and/or disclose certain information about me in order for it to carry out its various health care operations, including, or example carrying out quality assurance and improvement, business planning and other efforts the Practice has determined to be necessary and vital to properly conduct its operations. This consent to release medical information may be revoked in writing by me at any time and such revocation shall be effective immediately, except to the extent that the Practice has take action in reliance upon my consent.

Patient Name

Date

Authorized Signature

Authority of Personal Representative (if applicable)



Accredited by
Accreditation Association
for Ambulatory Health Care, Inc.