



CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION PATIENT NAME: _____

SECTION A: PATIENT GIVING CONSENT

HOME# _____ WORK# _____ E-MAIL _____ SS# _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____

SECTION B: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

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.

NOTICE OF PRIVACY PRACTICES: YOU HAVE THE RIGHT TO READ OUR NOTICE OF PRIVACY PRACTICES BEFORE YOU DECIDE WHETHER TO SIGN THIS CONSENT. OUR 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 OF OTHER IMPORTANT MATTERS ABOUT YOUR PROTECTED HEALTH INFORMATION. A COPY OF OUR NOTICE ACCOMPANIES THIS CONSENT. WE ENCOURAGE YOU TO READ IT CAREFULLY AND COMPLETELY BEFORE SIGNING THIS CONSENT.

WE RESERVE THE RIGHT TO CHANGE OUR PRIVACY PRACTICES AS DESCRIBED IN OUR PRIVACY PRACTICES. IF WE CHANGE OUR PRIVACY PRACTICES, WE WILL ISSUE A REVISED NOTICE OF PRIVACY PRACTICES, WHICH WILL CONTAIN THE CHANGES. THOSE CHANGES MAY APPLY TO ANY OF YOUR PROTECTED HEALTH INFORMATION THAT WE MAINTAIN.

YOU MAY OBTAIN A COPY OF OUR NOTICE OF PRIVACY PRACTICES, INCLUDING ANY REVISIONS OF OUR NOTICE, BY CONTACTING: (P): 860-633-0486 (F): 860-659-2126 (E): GLASTONBUR@SBCGLOBAL.NET (A): 131 NEW LONDON TURNPIKE SUITE 211, GLASTONBURY, CT 06033

METHODS OF DISCLOSURES: I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY)

HOME TELEPHONE _____

- O.K. TO LEAVE MESSAGE WITH DETAILED INFORMATION
- LEAVE MESSAGE WITH CALL BACK NUMBER ONLY

WORK TELEPHONE _____

- O.K. TO LEAVE MESSAGE WITH DETAILED INFORMATION
- O.K. TO LEAVE MESSAGE WITH CALL-BACK NUMBER ONLY

WRITTEN COMMUNICATION _____

- O.K. TO MAIL TO MY HOME ADDRESS _____
- O.K. TO MAIL TO WORK /OFFICE ADDRESS _____
- O.K. TO FAX TO THIS NUMBER _____
- O.K. TO E-MAIL TO _____

RIGHT TO REVOKE: YOU WILL HAVE THE RIGHT TO REVOKE THIS CONSENT AT ANY TIME BY GIVING US WRITTEN NOTICE OF YOUR REVOCATION SUBMITTED TO THE CONTACT PERSON LISTED ABOVE. PLEASE UNDERSTAND THAT REVOCATION OF THIS CONSENT WILL NOT AFFECT ANY ACTION WE TOOK IN RELIANCE ON THIS CONSENT BEFORE WE REVOCATION, AND THAT WE MAY DECLINE TO TREAT YOU OR TO CONTINUE TREATING YOU IF YOU REVOKE THIS CONSENT.

I, _____, HAVE HAD FULL OPPORTUNITY TO READ AND CONSIDER THE CONTENTS OF THIS CONSENT FORM AND YOUR NOTICE OF PRACTICES. I UNDERSTAND THAT, BY SIGNING THIS CONSENT FORM, **I AM GIVING MY CONSENT TO YOUR USE AND DISCLOSURES OF MY PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT ACTIVITIES AND HEALTH CARE OPERATIONS.**

SIGNATURE _____ DATE _____

IF THIS CONSENT IS SIGNED BY A PERSONAL REPRESENTATIVE ON BEHALF OF THE PATIENT, COMPLETE THE FOLLOWING:

PERSONAL REPRESENTATIVE'S NAME _____ RELATIONSHIP TO PATIENT _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. INCLUDE COMPLETED CONSENT IN THE PATIENT'S CHART.

RECOVATION OF CONSENT

I REVOKE MY CONSENT FOR YOUR USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT ACTIVITIES, AND HEALTHCARE OPERATIONS.

I UNDERSTAND THAT REVOCATION OF MY CONSENT WILL NOT AFFECT ANY ACTION YOU TOOK IN RELIANCE ON MY CONSENT BEFORE YOU RECEIVED THIS WRITTEN NOTICE OF REVOCATION. I ALSO UNDERSTAND THAT YOU MAY DECLINE TO TREAT OR TO CONTINUE TO TREAT ME AFTER I HAVE REVOKED MY CONSENT.

SIGNATURE _____ DATE _____

FOR OFFICE USE ONLY

WE ATTEMPTED TO OBTAIN WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES, BUT ACKNOWLEDGEMENT COULD NOT BE OBTAINED BECAUSE:

- INDIVIDUAL REFUSED TO SIGN
- COMMUNICATIONS BARRIERS PROHIBITED OBTAINING THE ACKNOWLEDGEMENT
- AN EMERGENCY SITUATION PREVENTED US FROM OBTAINING ACKNOWLEDGEMENT
- OTHER (PLEASE SPECIFY) _____