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Consent for Release and Use of Confidential Information
Receipt of Notice of Privacy Practices Form

I, _____, hereby give my consent to Dr. Hale
(Name of Patient or Authorized Agent)
and Associates, to use or disclose, for the purpose of carrying out treatment,

payment, or health care operations, all information contained in the record of

_____.
(Patient's name)

I acknowledge receipt of the physician's Notice of Privacy Practice. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved the right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available via mail or in person.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Signed: _____Date:_____

If you are not the patient, please specify your relationship _____

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An attempt was made to obtain a signature of receipt of the physician's Notice of Privacy Practices. This was unsuccessful and is documented below.
Date:_____By:_____Reason:_____