CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Name: ____

Date of Birth: ______________________ Date: ____________________________

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 handbook before you decide whether to sign this consent form. This notice provides a description of our treatment, payment activities, and healthcare operations, of the use and disclosures we may make of your protected health information, and other important matters about your protected health information. A copy of our notice accompanies this consent form. 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 Notice of Privacy Practices handbook. If we change our privacy practices, we will issue a revised notice which will contain all changes. Those changes may apply to any of your protected health information we maintain.

You may obtain of a copy of our Notice of Privacy Practices, including any revisions of our notice, at any time by contacting either office location's personal office manager.

Conway: 1-843-248-3843
Murrells Inlet: 1-843-397-5337

RIGHT TO REVOKE: You will have the right to revoke the consent at any time by giving us written notice of your revocation submitted to the office manager of each individual office location listed above. Please understand that revocation of this 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 or to continue treating you if you revoke this consent.

Please list anyone you would like to be allowed to review your protected health information if/when in the event you are unavailable:

1. ____________________________________ **3.** ____________________________________
2. ____________________________________ **4.** ____________________________________

SIGNATURE: I, (print name) ____, have had full opportunity to read and consider the content of this Consent Form and your Notice of Privacy Practices handbook. 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.

Signature: ____ Date: ______________________________

IF this consent is signed by a personal representative/parent guardian on behalf of the patient, please complete the following:

Representative's Name: ____
Relationship to patient: ____
Signature: ____
Date: ____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT FORM AT ANYTIME.