Consent For Use Of Protected Health Information

I give consent to Dr. Muck's office to use and disclose my protected health information for my treatment and for payment.

Our notice of Privacy Practices provides more detailed information about how we may use and disclose information about you. You have the right to review our notice before you sign this consent.

We can change the terms of our notice. Our current notice can be found in our patient access area.

You can request that we restrict how we use and disclose your protected health information for the purpose of treatment, payment and healthcare operations. We will accommodate your request if we can, but we are not obligated to do so.

We may use your health information to send you additional information about services of programs, related to your healthcare. If you object to receiving this type of information from us, please initial here_____.

You may revoke your consent at any time. Your revocation must be in writing, signed by you or your personal representative on your behalf. Your revocation will be effective when we receive it. Your revocation will not be effective to the extent that we or others acted in reliance on your original consent.

X_____ X_____

Signature of Patient Signature of personal representive

X_____ X_____

Name of Patient-Print Name of representative-print

X_____ X_____

Date Date