



**Consent for Use or Disclosure of Health Information**  
**Our Privacy Pledge**

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to disclose your health information:

- \* We may have to disclose your health information to another health care provider or hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- \* We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- \* We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have a right to review that notice before you sign this consent form (164.520). We reserve the right to change our privacy policy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of you privacy notices.

**Your Right to Limit Use or Disclosures**

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

**Your Right to Revoke Your Authorization**

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree with its terms. I am also acknowledging that I have received a copy of this notice.

**Appointment Reminders and Health Care Information Authorization**

Your physician and members of the practice staff may need to use you name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organization to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we already released your health information before we receive your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may be no longer protected by the federal privacy rules. You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (164.524).

This notice is effective as of \_\_\_\_\_. This authorization will expire seven (7) years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

I also understand that my insurance will be filed for me and that benefits will be paid directly to The Taub Group. I understand that I may be asked to assist in obtaining proper payment from my insurance company and I agree to do so. I understand that if I do not have insurance that payment is expected at the time of service and I am solely responsible for all charges incurred.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Personal Representative Name (Printed)

\_\_\_\_\_  
Personal Representative Signature/Relationship to Patient