

# St. Peter Medical Center, P.C

## Labeed Nouri, MD

### Consent For Use/ Disclosure of the Health Information

Patient's Name: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_

Patient's SSN: \_\_\_\_\_

#### Notice to Patient:

By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of the **treatment**, various activities associated with **payment** and **health care operations**. Our notice of **Privacy Practices provides** more details on our treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, Please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding you health care information.

As stated in our Notice of Privacy Practices, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to your health care information, you have the right to receive a copy by contracting our Privacy Officer.

You have the right to **revoke** your consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You should also understand that if you revoke this Consent we may decline to treat you.

You are entitled to a copy of this **Consent Form** after you have signed it.

(To be completed by Patient or Patient's Representative)

I, \_\_\_\_\_, have read the contents of this Consent Form and the Notice of Privacy Practices. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment activities and any health care operations.

\_\_\_\_\_  
Patient's signature or Signature of Patient's representative.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient's Representative

\_\_\_\_\_  
Relationship to Patient