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PATIENT CONSENT FOR PHYSICIAN TO USE OR DISCLOSE HEALTHCARE INFORMATION FOR TREATMENT, PAYMENT, AND/OR HEALTHCARE OPERATIONS

PATIENT'S NAME: ____

DATE OF BIRTH: ___________________________ SSN: ___________________________

I understand that my health information is private and confidential. I understand that Dr. Paul Grayson Smith, JR., D.O., P.C. intends to protect my privacy and the confidentiality of my personal health information.

I understand that signing this form means that Paul Grayson Smith, JR., D.O., P.C. and his staff may use and disclose my personal health information to help provide medical care, handle billing and payment of my account, and to take care of any other healthcare operations.

The office of Paul Grayson Smith, JR., D.O., P.C. has a detailed form called the "Notice of Privacy Practices" which contains more information about the policies and practices used to protect patient privacy. I have been given a copy of the notice before signing this agreement. I understand that this notice may be updated or revised at any time without notification. Upon my request, the office will provide me with the most current version.

Under the terms of this consent, I can request in writing that Paul Grayson Smith, JR., D.O., P.C. and his staff restrict how my personal health information is used or disclosed. I understand that I have the right to cancel this consent in writing at any time. It is possible that Dr. Smith and his staff have already used or disclosed information about me before cancelling this consent.

My signature below indicates that I have read a copy of the "Notice of Privacy Practices" for the office of Paul Grayson Smith, JR., D.O., P.C. and I understand my rights as a patient of this office.

____ ______________________________

Patient or Legal Guardian Date

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Witness from Office