CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

You may refuse to sign any part of this form. You may request a copy for your files.

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 health care operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities and healthcare operations of the uses and disclosures we may make to your protected health information, and of other important matters about your protected health information. A copy of your notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent. With this consent, Dr. Chila's office may call my home or other alternative locations and leave a message or voice mail. This message or voicemail may be in reference to any items that assist our practice in carrying out treatment, payment, and healthcare operations such as appointments, reminders, insurance items and any calls pertaining to your clinical care including laboratory results.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revision of our Notice at any time by contacting the office @ 610-642-0185.

Right to Revoke: You will have the right to revoke this consent at any time by giving our office written notice of your revocation. Please understand that revocation of the 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.

ACKNOWLEDGMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICE

I, (please print) _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices, 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:** _____

Address: _____

* If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Representative: _____ Relationship to Patient: _____

FOR OFFICE USE ONLY

We obtained written acknowledgement of receipt of our Notice of Privacy Practices_____

We attempted but were unable to obtain written acknowledgement of receipt of our Notice of Privacy Practice to:

_____