

CONSENT FOR USE AND DISCLOSURE OF  
HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Address: \_\_\_\_\_ Patient Number: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

SECTION B: TO THE PATIENT – 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 healthcare 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 of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

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.

Contact Person: Michael S. Korenfeld, M.D. Telephone: 636-390-3999  
Address: 901 E. 3<sup>rd</sup> St Washington, MO 63090 Fax: 636-390-5959

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that the revocation of this 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 continue treating you if you revoke this Consent.

Signature: \_\_\_\_\_

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this consent form and your Version 1 of the Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to you to use and disclose my protected health information to carry out treatment, payment activities and health care operations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

Personal Representative's Name: \_\_\_\_\_

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