**Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practices Form**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby give my consent to the Center for Adult and

 (*Name of Patient or Authorized Agent*)

Pediatric Wellness to Use or disclose, for the purpose of carrying out treatment, payment, or health care operations (TPO), all information contained in the patient record of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

(*Patient’s Name*)

 I acknowledge receipt of the physician’s Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

 I understand that Dr. Joudeh has reserved a right to change his privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available via mail.

 With this consent, the Center for Adult and Pediatric Wellness may call, mail to, or email my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, or clinical information. I have the right to request that the practice restrict how it uses or discloses my protected health information to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

 I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician’s office.

Signed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

If you are not the patient, please specify your relationship to the patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.