



**Consent To the Use and Disclosure of Personal Health Information for Treatment,
Payment or Health Care Operations**

I, _____, DOB _____, understand and agree that Dr. Carol L. Clark may use and disclose protected health information, including but not limited to name, address, health history, symptoms, examination and test results, diagnosis and treatment, for payment or health care operations. I understand that I must consent to this use and disclosure in order to enroll in or receive services through Dr. Clark.

I understand that I have been provided with a copy of the document entitle **Notice of Privacy Practices** that provides a complete description of potential uses and disclosure of my protected health information. I understand that I have the right to review the **Notice of Privacy Practices** prior to signing the consent.

I understand that Dr. Clark reserves the right to change her privacy practices and will provide a copy of any revised material at my next appointment or will mail one to me upon my request to the address that I have provided. **The Notice of Privacy Practices** is posted in the office waiting room.

I understand that I have the right to request that Dr. Clark restricts how protected health information is used or disclosed to carry out treatment, payment or health care operations. I further understand that Dr. Clark is not required to grant any request to restrict the use or disclosure of information. If, however, Dr. Clark agrees to the requested restriction, the restriction is binding on her.

I agree that I have the right to revoke this Consent in writing, except to the extent that Dr. Clark has already relied upon it. I understand that if I do revoke this Consent, Dr. Clark may choose to discontinue providing me with healthcare treatment and services.

Client or Personal Representative Signature

Date

Witness

Title

Date



**Notice of Privacy Practices
Receipt and Acknowledgement of Notice**

Client Name: _____

DOB: _____ Date of Intake: _____

SSN: _____

I acknowledge that I have received and have been given an opportunity to read a copy of the **Notice of Privacy Practices** for Dr. Carol L. Clark PA. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Dr. Clark at 305-757-6070.

Client Signature Date

Signature of Parent, Guardian or Personal Representative Date

Witness Date

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

If a client's representative refuses to sign acknowledgement of receipt notice, please document the date and time the notice was presented to the client and sign below.

Client Refuses to Acknowledge Receipt:

Presented on: Date _____ Time _____

Signature of Staff Member