Practice Member Health Information Consent Form

This form is to inform you about how your health information will be used

1. Your Health Information will only be used in this office for your care and will never be shared with anyone without your consent.

2. You can request a copy of your health records at any time.

3. Your written consent will only need to be obtained one time as long as you use this office for your care.

4. I have no staff who will have access to your records.

5. If you refuse to sign this consent, the practitioner has the right to refuse care.

I have read and understand how my Health records will be used and I agree to these policies and procedures.

Printed Practice Member Name _____

Date_____

Signature of Practice Member_____