Samuel Chacon, MD
Charlene Knedgen APRN

CONSENT TO USE & DISCLOSE
PROTECTED HEALTH INFORMATION

PATIENT'S NAME: _____ **BIRTHDATE:** _____

How we may use and disclose your health information.
Your protected health information will be used by Samuel Chacon MD or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day -to-day health care operations of the practice.

The notice of privacy practices.
Samuel Chaco MD is required to provide you a notice that describes how information about you may be used and disclosed. Additionally, we must provide you information on how you may get access to this information. These policies and practices are defined in the "**Notice of Privacy Policies and Practices**" brochure available to you. Please review it carefully.

You may place restrictions on the use or disclosure of your health information.
You may request a restriction on the use or disclosure of our protected information. However, our office may or may not agree to your request to restrict the use or to activate this request. Please consult with a practice representative or the Privacy Officer if you would like additional information or clarification.

It is a violation of the federal privacy standards if Samuel Chacon MD ***agrees*** and fails to comply with your request. The restrictions requested will not affect use and disclosure of your information prior to the date of your request. If you still have questions after reviewing the Notice of Privacy Brochure, please consult with a practice representative or the Privacy Official at the location and contact information listed on the back of the brochure.

You may revoke this consent at any time.
You may revoke this consent at any time; however, Samuel Chacon MD requires that you must revoke this consent in writing. If you choose to revoke this consent, the revocation will not affect the use and disclosure prior to the date of your request.

Changes to privacy practices.
Samuel Chacon MD reserves the right to change or modify the privacy practices outlines in the **Notice of Privacy** brochure. Samuel Chacon MD will notify you of any changes of privacy practices either by mail, at your next appointment, or another pre-approved method that you request.

Signature.

I have reviewed this consent form, received the brochure entitled **"Notice of Privacy Policies and Practices"** and give my permission to Samuel Chacon MD to use and disclose my health information in accordance with this consent and the notice provided.

I understand that I was provided with an option to receive a copy of the Privacy Practices and have waived that option. This is posted in the practice waiting area and can be located on the website.

Patient's Name: _____

Patient's Signature: _____ **Date:** _____

Guardian's Name is patient is a minor: _____ **Relationship to patient:** _____

Guardian's Signature: _____ **Date:** _____