C. Scott Moreland, D.O., PLLC

Child, Adolescent, & Adult Psychiatrist

12946 Dairy Ashford Road, Suite 260

Sugar Land, Texas 77478

Phone: 281-242-2595/ Fax: 281-242-2909

www.sugarbendcenter.com

Consent for Evaluation/Treatment

Patient's Name: ____________________________________ Date of Birth: ____________________

I____, hereby give full consent for child to receive services of C. Scott Moreland, D.O., PLLC until I notify him or he determines services are no longer appropriate or will no longer be provided. I certify that I have the legal authority to authorize and consent to this treatment or evaluation as parent, managing conservator, or guardian of this child. For this document, treatment refers to therapy, medication management, or both. If medication is an option, then I will be referred to a separate medication consent.

CONFIDENTIALITY

I understand that any information I or my child provides to C. Scott Moreland, D.O., PLLC. is confidential and generally will not be released to others without my written consent. However, I understand that professional ethical obligations, state and/or federal law might require C. Scott Moreland, D.O., PLLC. to disclose confidential information without my consent in certain circumstances. I understand C. Scott Moreland, D.O., PLLC. may be required to disclose confidential information, without my consent, in one or more of the following situations:

In the event that the therapy session reveals any information concerning the abuse of a child, elder or disabled person, C. Scott Moreland, D.O., PLLC. is mandated by law to make a report to the proper authorities. By signing this document, I acknowledge my awareness of this fact.

If the course of treatment reveals any intent my child may have to harm either himself/herself or others, I acknowledge C. Scott Moreland, D.O., PLLC's legal and moral duty to prevent my child from bringing this harm about. I specifically give my irrevocable permission to warn those parties she feels may be harmed. If my child reveals an intent to harm himself/herself, C. Scott Moreland, D.O., PLLC has my permission, also irrevocable, to prevent my child from accomplishing that intent.

If my child has been referred to this practice by a managed care or insurance company, or I plan to request C. Scott Moreland, D.O., PLLC to file for reimbursement with a managed care or insurance company, I am aware of this arrangement. As a requirement of the managed care or insurance company, I understand C. Scott Moreland, D.O., PLLC. may be required to provide them with a complete copy of the records generated in my child's therapy. Once these records are in the possession of the managed care or insurance company, C. Scott Moreland, D.O., PLLC cannot guaranty their continued confidentiality.

Additionally, if a law suit is filed by me or my child against C. Scott Moreland, D.O., PLLC for breach of duty; or if a court order, legal proceeding, statute, or regulation requires disclosure of records, I understand legal obligations may require the release of my child's therapy records.

RECORDS

I understand it is stated law that mental health professionals maintain a record of the treatment given to me. This record will contain the information that will allow Dr. Moreland to chart the course of treatment. He will use it only for that purpose. It is his intent that no one will ever see what is contained in the file. I understand I may get a copy of the file only by providing him with a signed release of information request. Dr. Moreland may provide me with a synopsis of the course of treatment and outcome in lieu of the actual record. I agree I will pay in advance for either the copying cost of the actual record or the time required for the preparation of the treatment summary. This includes providing copies or reports to any court or legal representative or designate. In the event of your death, these requirements will be binding on any heirs, successors or executor(s).

If the treatment sessions contain more than one patient, I agree that no one person may get the complete treatment file. I agree Dr. Moreland, may synopsize the course of each individual's treatment as opposed to providing a copy of what notes

may have been made during any treatment session. I also understand that if Dr. Moreland believes certain information in the chart will be detrimental to me or my child's health that information will be blacked out.

If I have been referred to this practice by a managed care or insurance company, or I plan to request Dr. Moreland, file for reimbursement with a managed care or insurance company, I am aware that he may have to waive my right to confidentiality as it pertains to in the managed care or insurance company. If he is an approved provider, he may have to share all the information I provide with this organization. I understand Dr. Moreland, will do so as required to get me all the treatment that is appropriate. I am aware that the organization is not bound by her ethical and legal requirements on maintaining the confidentiality my treatment may require. Once these records are in the possession of the managed care or insurance company, Dr. Moreland, cannot guarantee their continued confidentiality.

PAYMENT:

I understand payment is due at the time of service. Forms of payment accepted are Discovery, MasterCard, Visa, cash or check.

MISSED/RESCHEDULED APPOINTMENTS:

If I need to cancel or reschedule an appointment with Dr. Moreland, I agree to contact his office at least 24 hours in advance. This will allow those who are waiting for an appointment the opportunity to be scheduled in my place. **If I do not provide this notice, I understand I need to pay a $75.00 'no cancellation' fee for each occurrence**. This fee is not covered by insurance and needs to be paid before or at the next appointment. A pattern of missed appointments may result in our referring you to a provider who can better accommodate your schedule.

TERMINATION OF TREATMENT

I understand the length of time required for treatment will be determined by my personal situation. I understand Dr. Moreland will do his best to fulfill my child's therapeutic needs and to provide his best professional care. For me and my child's part, I agree to participate in the process to the best of my ability. It is intended that when my child's needs are met, to the extent that they can be, we will terminate our relationship.

I understand for my child's part, my child may terminate treatment at any time. This may be accomplished in any one of several ways. These include, but are not limited to, putting it in writing, informing me verbally, failing to maintain my appointment schedule without proper notification, or failure to follow treatment recommendations. I understand Dr. Moreland will respect me or my child's wishes to terminate treatment. I also understand the method I choose to accomplish termination will impact any decision to resume a therapeutic relationship with him.

My signature on this consent form verifies that I have had the opportunity to ask questions regarding procedures, policies, and therapeutic techniques, that my questions were answered to my satisfaction by Dr. Moreland, and that I voluntarily give my consent for treatment. I understand that I have the right to withdraw my consent for treatment at any time.

_______________________________ _______________________________

Parent's Signature Date

____

Printed Name of Parent

Child/Teen History Questionnaire

Please take a few moments to complete this history questionnaire.

Child's Name: ______________________________ **Today's Date:** __________

Date of Birth: ______________ **Age:** __________ **Grade:** __________

Your Name: ____

Address: ____

City:______________________________ **Zip:** ______________

Mother:____________________**Father:** ____________________

Home Phone: ____________________ **Leave message on this line? Yes No**
Mom's Work Phone: ____________________ **Leave message on this line? Yes No**
Dad's Work Phone: ____________________ **Leave message on this line? Yes No**
Mom's Cell Phone: ____________________ **Leave message on this line? Yes No**
Dad's Cell Phone: ____________________ **Leave message on this line? Yes No**
Child's/Teen's Cell Phone:____________________ **Leave message on this line? Yes NO**
Mom's Email Address: ____________________ **May we contact you via email? Yes No**
Dad's Email Address: **May we contact you via email? Yes No**

See separate consent for Email Communication

How did you find out about me? ______________________________

Primary Physician's Name: ______________________________

Address: ____

Telephone: ____
With your consent, may we contact your child's physician? Yes No

Please state why you are seeking consult/evaluation at this time: ______________________________

____

____

____

____

At what age was this problem first noted?______________________________

What areas in your child's life (family, school, peers, etc.) are affected and how? ____________________

____

____

What interventions/treatment have you tried? ____

____

What are you hoping to achieve from today's evaluation?

____

____

Birth History: How much did your child weigh at birth? ______pounds_________ounces

Child was born by C-section: Y N If yes, specify: planned emergency

Child was born at ____________ weeks old and left hospital on day of life: ____________________

Mother's age at birth of this child____________ Number of pregnancies prior to this child:______

Father's age at birth of this child:____________ Number of miscarriages prior to this child:______

Were there any problems during the pregnancy? No Yes, please specify: _______________

____

Circle any condition that occurred during delivery:

Cord around neck	Breathing difficulty	Required oxygen
Had an infection	Difficulty sucking	Jaundiced

*Please describe: ____

____

Any other concerns during labor/delivery or following this child's birth? No Yes, please specify: ______________

____

During the pregnancy, were any substances or medications used by the mother or father? (including beer/wine, tobacco, marijuana, prescription meds, crystal/cocaine) ____

____

Developmental History/Concerns:

At what age did your child: Sit up: Crawl: Walk: ____________________

Has your child ever had Occupational and/or Physical Therapy? No Yes, please explain: ______________

At what age did this child: Speak first word?: Put 2-3 words together?: ____________

Any history of speech delays,
Stuttering or speech therapy? No Yes, specify: ________________________________

When was the child toilet trained? For urination: ____________ For Bowel: ____________________

Any problems with bed wetting,
daytime urine accidents or soiling? No Yes: ____

My child gets along better with kids: younger the same age older

Medical/Psychiatric History: Last physical exam was: ____________________________________

Last hearing check: ______________________ Last vision screen: ______________________

List any abnormal findings: ______________________

List any serious illnesses, injuries, hospitalizations, or surgeries: None

List incidents and dates ______________________

Does your child have any of the following medical conditions?

Current	Past		Current	Past	
		Heart Problems			Head Injury
		Digestive problems			Asthma
		Migraines			Overweight
		Hypothyroidism			Seizures
		Hyperthyroidism			Arthritis
		Diabetes			High Blood Pressure

Please explain any current or past medical conditions:

Are there any serious medical problems that run in the family?

Has your child or anyone in the immediate family had symptoms of early heart disease? (Including but not limited to arrhythmias, chest pain, and/or heart attack less than 40 years old)

Is your child currently taking any medications? If so, please list them with dosage and reason. Vitamins, Herbal supplements?

Has your child ever seen a psychiatrist, psychologist or therapist? No Yes Was it helpful?:

Please list all past medications used to treat emotional and behavioral concerns, the dose, reason for their use, reason why they were stopped and any significant side effects. Include alternative treatments, if any.

Name of Medication	**Dose**	**Age**	**Reason started**	**Reason stopped**	**Was it helpful?**	**List any side effects, adverse reactions**

Please check all that apply:

Co-morbid Conditions:	**Child, Current**	**Child, Past**	**Mother**	**Father**	**Sibling**	**Other**
Depression, Sadness						
Anxiety, excessive worry						
Obsessions &/or Compulsions						
Autism/Asperger's						
Mental Retardation						
Suicidal thoughts						
Attempted Suicide						
Learning Disabilities						
Attention Deficit/Hyperactivity						
Problems with Anger						
Problems with Assertiveness						
Oppositional/Defiant						
Schizophrenia or Psychosis						
Tourette's Syndrome						
PTSD						
Heavy Alcohol Use						
Drug Use/Abuse						
Eating Disorders						
Abused in any way						
Psychiatric Hospitalization						
Bipolar/manic episodes						
Other:						

Review of Systems:

Has there been any major changes/stressors in this child's life? (death of a family member, change of school, move, new baby brother, sister, or death of a pet, etc) No Yes, specify what and age of child ______________________________

____

Does your child currently (past 6 months) display any of the following behaviors intensively or frequently?

Low frustration tolerance	Impulsivity	Inattention	Hyperactivity
Poor self esteem	Poor peer relations	Tics	Repetitive movements
Forgetfulness	Irritability	Sadness, crying	Social withdrawal
Nervousness	Oppositional behavior	Distractibility	Sleep problems
Decreased grades	Skipping school	Temper tantrums	Suicidal behavior
Aggression	Unwilling to change routine	Constantly worries	Frequent headaches, stomachaches

Academic Information:

Child's School:____ Grade: __________

School's Address/Phone: ____________________

Contact Person at School: (name, title and phone #)

____

Is your child in any special programs other than regular classes: No Yes, please circle: Speech Therapy

Resource Content Mastery Special Ed GT Occupational/Physical therapy Other:

Does your child receive any academic modifications/504? Please describe: ____________________

____

Do you have concerns about your child's academic performance? Please describe:

____

____

Teachers report problems with: (i.e. reading, math, attention, behavior, social skills): ____________________

____

Does your child have a current IEP, Individual Educational Plan? No Yes: ____________________

____

Has your child had any previous educational, neuropsychological or psychological testing? If so, when and where? What were the results? (**Please bring a copy of testing**) ____________________

____

____

Family:

Please list family members who live in the home and their ages:

____________________ ____________________

____________________ ____________________

____________________ ____________________

Are there any family members who live elsewhere? Please list their names, ages and reason for moving out. ____________________

____

Mother's highest level of education: ____________________
Mother's employment status/current job: ____________________

Father's highest level of education: ____________________
Father's employment status/current job: ____________________

Parents divorced? Yes or No. Has either, or both, parent remarried? ____________________

____

If divorced, what are the custody arrangements? ____________________
Does either parent travel frequently? How often? ____________________
Are there other significant people in your child's life (i.e. grandma, nanny, etc)

____

____

Recreation/Social:

How does your family spend “free time”? ____

____

What are your child’s favorite hobbies and interest? ____

____

How many good friends does your child have? ____

Does he/she have a best friend? ____

Does your child have difficulty making and/or keeping friends? No Yes, specify: ______________________

____

Are you concerned about your child’s social skills? No Yes, specify: ______________________

____

Please check the following activities in which your child participated in the last month:

- Played with a friend outside of school, how frequently? ____________________
- Exercised/played a sport, how frequently?____________________
- Engaged in group activities outside of school, what activities? ____________________
- Read or was read to, how frequently? ____________________
- Watched T.V., how many hours/day? ____________________
- Played video games, how many hours/day?____________________

Please summarize your child’s overall functioning (emotional, behavioral, biological, and psychological) by choosing **ONE** number below. Compare your child’s functioning in 3 settings – home, school, and with peers, to ‘average children’ his/her own age that you are familiar with. **Please circle only one**:

1: **Excellent** functioning/ No impairment in settings
2: **Good** functioning/ rarely shows impairment in settings
3: **Mild** difficulty in functioning/ Sometimes shows impairment in settings
4: **Moderate** difficulties in functioning/ usually shows impairment in settings
5: **Severe** difficulties in functioning/ Most of the time shows impairment in settings
6: **Needs considerable supervision** in **all** settings to prevent from hurting self or others
7: **Needs 24-hour professional care & supervision** due to severe behavior or gross impairment(s)

Please discuss several strengths your child has:

____

____

____

Do you have any other comments that you think would be helpful?

____

____

____

____

____

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Consent for Communication with Primary Care Provider

Dear Parent(s)
To provide the best care for your child and in an effort to coordinate the care of my patients with their providers in the community, I am requesting your permission to inform your child's primary care physician about your participation in assessment and/or treatment with me. At times, speaking with a child's primary care physician is helpful, especially concerning issues of medication, treatment follow-up, and psychological issues impacting your child's well-being. Moreover, as your child's primary care physician carries the responsibility for your child's medical care, it is important that he/she has access to information related to your child's health and treatment. Conversely, in making treatment recommendations, it is imperative that I am also aware of your child's health and any medical issues of concern.

Please complete the following information:

______________________________	______________________________
Child's Name	Date of Birth

PHYSICIAN INFORMATION:

______________________________	______________________________
Name of Physician	Physician's Phone Number
______________________________	______________________________
Physician's Address	City, State, and Zip

CONSENT

- I,__________________________________, hereby give C. Scott Moreland, D.O. &/or his designated staff, permission for the mutual exchange of pertinent information with my child's primary care physician, including academic, social, medical, psychological, and/or psychiatric information.

- I,__________________________________, hereby decline to give C. Scott Moreland, D.O. &/or his designated staff, permission for the mutual exchange of pertinent information with my child's primary care physician.

______________________________	______________________________
Signature	Date
______________________________	______________________________
Printed Name	Relationship to Patient
______________________________	______________________________
Witness	Date

This consent is valid while in treatment with Dr. Moreland.

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Consent for Communication with School

Please complete the following information:

______________________________	______________________________
Child's Name	Date of Birth

SCHOOL INFORMATION:

______________________________	______________________________
Name of school	School's Phone Number
______________________________	______________________________
School's address	City, State, and Zip
______________________________	______________________________
Name of Principal	Name of Counselor
______________________________	______________________________
Name of Teacher	Name of Teacher

CONSENT

- o I,_________________________________, hereby give C. Scott Moreland, D.O. and/or his designated staff, permission for the mutual exchange of pertinent information with my child's school personnel, including academic, social, medical, mental health/psychological, and/or psychiatric information.
- o I,_________________________________, hereby decline to give C. Scott Moreland, D.O. and/or his designated staff, permission for the mutual exchange of pertinent information with my child's school personnel.

____

Signature Date

____

Printed Name Relationship to patient

____

Witness Date

This consent is valid while in treatment with Dr. Moreland.

TO BE COMPLETED BY DIVORCED PARENTS SEEKING TREATMENT FOR THEIR CHILD

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Documentation of Right to Seek Mental Health Treatment for Child

Child's Name: ________________________________ Date of Birth: ______________

By signing below, I certify that I have the legal right to seek mental health treatment for the child identified above. I understand that before treatment can begin I must provide a copy of the divorce decree with the section identifying my right to seek mental health treatment clearly highlighted.

_______________________________________ ____________________
Signature of Parent/Guardian Date

____
Printed Name of Parent/Guardian

_______________________________________ ____________________
Signature of Parent/Guardian Date

____
Printed Name of Parent/Guardian

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NOTICE OF PRIVACY PRACTICES

IN ACCORDANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA), THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AS WELL AS HOW YOU MAY GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY AND SIGN THE ACKNOWLEDGEMENT OF RECEIPT.

Protecting Your Personal and Health Information

This notice will explain how we handle your medical/mental health information. Applicable federal and state laws require us to maintain the privacy of clients' personal and health information. In this Notice, your personal or protected health information is referred to as "health information" or "PHI" and includes information regarding your health care and treatment with identifiable factors, such as your name, age, address, income or other financial information. Because state and federal laws, combined with our professional ethics, are very complicated, some parts of this notice are very detailed and may seem difficult to understand. Please know C. Scott Moreland, D.O., PLLC is committed to protecting the privacy of your health and personal information and is available to answer any questions you may have.

How We Protect Your Health Information

C. Scott Moreland, D.O., PLLC. protects your health information by treating all of your health information that he collects as confidential (for exceptions to confidentiality see Consent for Treatment), by training all staff in federal and state confidentiality policies and practices per HIPAA, by restricting access to your health information only to those office staff that needs to know your health information in order to provide her services to you, and by maintaining physical, electronic, and procedural safeguards to comply with federal and state regulations guarding your health information.

Uses and Disclosures for Treatment, Payment, and Health Care Operations

C. Scott Moreland, D.O., PLLC. may use or disclose your protected health information for treatment, payment, and health care operations purposes if you have given consent to receive evaluation or treatment services.

Clarification of terms:
PHI- information in your health record that could identify you.
Treatment, Payment, and Health Care Operations
Treatment- when office provides, coordinates, or manages your health care and other services related to your health care. An example of treatment would be when our office consults with another health care provider, such as your family physician.
Payment- when you provide reimbursement for the services you receive in the office. An example of payment would be when our office discloses your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
Health Care Operations – are activities that relate to the performance and operation of our office. Examples of health care operations are quality assessment and improvement activities, business related matters such as audits and administrative services, case management and care coordination, and conducting training and educational programs or accreditation activities.
Use – Activities within the office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
Disclosure – Activities outside of the office, such as releasing, transferring, or providing access to information about you to other parties.

Uses and Disclosures Requiring Authorization

C. Scott Moreland, D.O., PLLC and any administrators of his may use or disclose PHI for purposes outside Treatment, Payment, or Health Care Operations when your authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when the office is asked for information for purposes outside of Treatment, Payment, or Health Care Operations, we will obtain an authorization from you before releasing this information.
Specific authorization is also obtained before releasing your psychotherapy notes. Psychotherapy notes are notes made about treatment and are given a greater degree of protection than PHI.
You may revoke all such authorizations at any time, provided each revocation is in writing. After that time, we will not use or disclose your information for the purposes originally agreed upon. However, we cannot take back any information already disclosed with your permission or that we had used in our office.

Uses and Disclosures Not Requiring Consent or Authorization

The law lets C. Scott Moreland, D.O., PLLC use or disclose PHI without your consent or authorization in some cases. Here are some examples of when this might occur:

When Required by Law - Suspected child abuse must be reported. Also, if you are involved in a lawsuit or legal proceeding and the provider receives a subpoena, discovery request, or other lawful process, some of your PHI may have to be released. This will occur only after trying to tell you about the request, consulting your lawyer, or trying to get a court order to protect the information being requested. Finally, some information has to be disclosed to governmental agencies, which check on providers to see that privacy laws are being obeyed.
For Law Enforcement Purposes – Information may be released if your provider is asked to do so by a law enforcement official to investigate a crime or criminal.
For Public Health Activities – Some of your PHI might be disclosed to agencies which investigate diseases or injuries.
Relating to Decedents – PHI might be disclosed to coroners, medical examiners, or funeral directors, and to organizations relating to organ, eye, or tissue donations or transplants.
For Specific Government Functions – PHI of military personnel and veterans may be disclosed to government benefit programs relating to eligibility and enrollment. PHI may also be disclosed to Workers Compensation and Disability Programs, to correctional facilities if you are an inmate, and for national security reasons.
To Prevent a Serious Threat to Health or Safety – If your provider believes that there is a serious threat to your health or safety or that of another person or the public, the provider can disclose some of your PHI. This disclosure will only be provided to persons who can prevent the danger.

Patient Rights and Provider's Duties

Patient Rights:
Rights to Request Restrictions – You have the right to request that your provider limits what is told to people involved in your care or the payment of your care, such as family members and friends. C. Scott Moreland, D.O., PLLC may not be able to accept your request; however, if accepted she will uphold it except in case of emergency or if it is against the law.
Right to Receive Confidential Communications by Alternative Means/Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are being seen at the office. On your request, communications will be sent to an alternate address.)
Right to Inspect and Copy – You have the right to inspect and/or obtain a copy of your records. A reasonable fee may be charged for copying. Access to your records may be limited or denied under certain circumstances, but in most cases you have a right to request a review of that decision. On your request, we will discuss with you the details of the request and denial process.
Right to Amend – You have the right to request in writing an amendment of your health information for as long as PHI records are maintained. The request must identify which information is incorrect and include an explanation of why you think it should be amended. If the request is denied, a written explanation stating why will be provided to you. You may also make a statement disagreeing with the denial, which will be added to the information of the original request. If your original request is approved, we will make a reasonable effort to include the amended information in future disclosures. Amending a record does not mean that any portion of your health information will be deleted.
Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI. If your health information is disclosed for any reason other than treatment, payment, or operation, you have the right to an accounting for each disclosure of the previous six (6) years. The accounting will include the date, name of person or entity, description of the information disclosed, the reason for disclosure, and other applicable information. If more than one (1) accounting is requested in a twelve (12) month period, a reasonable fee may be charged.
Electronic vs. Paper – If you received this notice electronically (e.g., accessing a website) you have the right to obtain a paper copy of the notice from the office upon request.

Duties of C. Scott Moreland, D.O., PLLC
Provider is required by law to maintain the privacy of PHI and to provide you with this notice of legal duties and privacy practices.
C. Scott Moreland, D.O., PLLC reserves the right to change the privacy policies and practices and terms of this Notice at any time, as permitted by applicable law. He reserves the right to make the changes in privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Unless we notify you of such changes, however, the office is required to abide by the terms currently in effect.

Questions and Complaints

For questions regarding this Notice of our Privacy Practices, or if you are concerned that your privacy rights may have been violated, please contact C. Scott Moreland, D.O., PLLC. You may also make a written complaint to the US Department of Health and Human Services, whose address can be provided upon request. If you choose to make a complaint with the US Department of Health and Human Services, or with me, I will not retaliate in any way.

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CONSENT FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

In my notice of Privacy Practices, I provided you with information about I can use or disclose your personal and health information. As described in my Notice of Privacy Practices, I request your consent for use or disclosure of mental health and medical information to carry out treatment, payment, or health care operations. You have a right to review my Notice of Privacy Practices before signing this Consent form.

By signing this Consent form, you: (1) Acknowledge that a copy of the Notice of Privacy Practices has been provided to you; and (2) Consent to our use and disclosure of your health information for treatment, payment, or health care operations, as described in the Notice of Privacy Practices.

You have the right to revoke this Consent in writing any time, except where we have already used or disclosed your health information in reliance upon this Consent.

__________________________________ ___________________
Signature of Patient or Legal Representative Date

____
Patient’s Name (Printed)