

Darrel Pierce MD

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

HOW MAY WE USE AND DISCLOSE YOUR HEALTH INFORMATION?

Your protected health information will be used by Pierce MD, PLLC or disclosed to others for the purpose of treatment, obtaining payment or supporting the day day-to-day healthcare operations of the practice.

THE NOTICE OF PRIVACY PRACTICES:

Pierce MD is required to provide to 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 are defined in the "Notice of Privacy Policies and Practices" display in the front lobby/waiting area. PLEASE REVIEW IT CAREFULLY. If you need a copy of this notice, please check with the front desk.

YOU MAY PLACE RESTRICTIONS ON THE USE OR DISCLOSURE OF YOUR HEALTH INFORMATION:

You may request a restriction on the use or disclosure of your protected health information. However, Pierce MD may or may not agree to your request to restrict the use or disclosure of your protected health information. You may be asked to complete an authorization to activate this request. Please consult with a practice representative if you would like additional information or clarification.

It is a violation of the federal privacy standards if Pierce MD agrees and fails to comply with your request. The restrictions requested will not affect use and disclosure of your information before the date of your request. If you still have questions after reviewing the "Notice of Privacy Policies and Procedures", please consult with a practice representative.

YOU MAY REVOKE THIS CONSENT AT ANYTIME:

You may revoke this consent at anytime, however, Pierce MD requires that you must revoke this consent in writing. If you choose to revoke this consent, the revocation will not affect use and disclosure of your information before the date of the request.

CHANGES TO PRIVACY PRACTICES:

Pierce MD, PLLC reserves the right to change or modify the privacy practices outline in the "Notice of Privacy Policies and Procedure". Pierce MD, PLLC will notify you of any changes of privacy practices either by mail, at your next appointment or any other pre-approved method that you request.

SIGNATURE:

I understand the "Notice of Privacy Policies and Procedures" and give my permission to Pierce MD, PLLC to use and disclose my health information in accordance with this consent and the notice provided.

Name of Patient (Printed)

Signature of Patient

Patient Parent/Guardian/Representative

Signature of Parent/Guardian/Representative

Date