Ryan Crenshaw, M.D.
21135 Whitfield Place, #102
Sterling, VA 20165
(703) 444-4799

CONSENT FOR RELEASE OF INFORMATION FOR THE TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

I, ____, hereby authorize Dr. Ryan Crenshaw to use and or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and healthcare operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Dr. Crenshaw can refuse to treat me.

I have been informed that Dr. Crenshaw has prepared a notice ("Notice") that more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have the right to review such ("Notice") prior to signing this consent.

I understand that I may revoke this consent at any time by notifying Dr. Crenshaw in writing, but if I revoke my consent, such revocation will not affect any actions that Dr. Crenshaw took before receiving my revocation.

I understand that Dr. Crenshaw has reserved the right to change his/her privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request, that Dr. Crenshaw restricts how my individually identifiable health information is used and or disclosed to carry out treatment, payment, or health care operations. I understand that Dr. Crenshaw does not have to agree to such restrictions, but that once such restrictions are agreed to, Dr. Crenshaw must adhere to such restrictions.

____ ______________

Signature of patient or patient's representative Date

____

Printed name of patient or patient's representative

____

Relationship to patient

I refuse to sign this consent form, which acknowledges Dr. Crenshaw's implementation of HIPPA privacy regulations.

____ ______________

Signature of patient or patient's representative Date