Consent for Use and Disclosure c
Personal Health Information

This form authorizes us to use and disclose your protected health information (PHI) for the purposes of healthcare operations, treatment and payment activities.

Before signing, please read our Notice of Privacy Policies to gain a clear understanding of how we may use and disclose your PHI.

For questions concerning our Notice of Privacy Policies, please contact **Wendy Tonozzi**, Practice Administrator for Offerdahl and Associates.

You may reach her by telephone at **303-987-9109**.

Patient's Consent

Name: ______________________________
Address: ______________________________ State: ________ Zip: ________________
City: ______________________________ E-mail: ______________________________
Telephone: (______) ______________________ Social Security #: _______ _______ _______
Patient #: ______________________________

I, ______________________________________, have read your Notice of Privacy Policies and I consent to your use of my PHI for the purposes of healthcare operations, treatment and payment activities.

Signature: ______________________________________ Date: ____________________

If a personal representative on behalf of the patient signs this consent révocation, complete the following:

Personal Representative's Name: ______________________________________

Relationship to Patient: ______________________________________

Patient's Revocation

By signing below, you revoke your above consent for us to use and disclose your PHI. However, by doing so, we reserve the right to discontinue treatment for you. This revocation also does not negate any of our prior actions while acting under your consent.

Signature: ______________________________________ Date: ____________________

If a personal representative on behalf of the patient signs this consent revocation, complete the following:

Personal Representative's Name: ______________________________________

Relationship to Patient: ______________________________________