Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practices Form

I, ____________________________________, hereby give my consent to Legacy Medical Care Inc. to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of ____________________________ and date of birth of ___________________

(Patient's Name)

I acknowledge receipt of the practice's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the practice has reserved a right to change their privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be posted in the office and a copy provided upon your request.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the practice. I also understand that I will not be able to revoke this consent in cases where the practice has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the practice's office.

Signature: ____Date: ___________________

If you are not the patient, please specify your relationship to the patient ________________________________

Consent for Medical Services

Patient Name ____ Date of Birth___________________________

I hereby consent for myself or my child to receive medical services from Legacy Medical Care Inc. I understand that I may revoke my consent in writing at any time. I also understand that any information regarding my medical history or treatment will remain confidential unless disclosure is required under existing state and federal laws.

I acknowledge that I have received information regarding the services, practices and hours of operation and that all of my questions have been answered to my satisfaction.

By signing below, I acknowledge that I have received a copy of, read and understood my rights and responsibilities.

____ ________________________

Patient Signature Date

____ ________________________

Parent/Guardian Representative Signature Date

____ ________________________

Staff Witness Signature Date