Patient Consent

I consent to the use or disclosure of my protected health information by Dr. Hayden Goltz, D.O. and "the Practice" for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills and to conduct health care operations of the Practice.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the Practice. The Practice is not required to agree to the restrictions that I may request. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I have the right to revoke this consent, in writing, at any time, except to the extent that the Practice has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe that information may identify me.

I understand I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Practice. The Notice of Privacy Practices also describes my rights and the practice's duties with respect of my protected health information.

I understand that the Notice of Privacy Practices is posted in the waiting room. The Practice reserves the right to change the Notice of Privacy Practices. I understand that I may request a copy of the Notice of Privacy Practices by asking the receptionist for one during regular business hours.

I hereby authorize the following individual(s) to receive information from the Practice on my behalf.

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

_____
Signature of Patient of Personal Representative

_____
Print Name of Patient or Personal Representative

_____
Date