CARDINAL ENDOCRINOLOGY
1580 McLaughlin Run Road, Suite 212
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Consent for the Use or Disclosure of Protected Health Information

As required by the Health Insurance Portability and Accountability act of 1996, this practice may use your personal health information for the purposes of treatment, payment, or health care operations. The specific uses and disclosures that we intend to make are described in our Notice of Privacy Practices. You have the right to review restrictions of the uses and disclosures in the Notice of Privacy Practices by describing the requested restrictions in the "restriction request" section of this form. You may revoke this consent at any time by signing and dating the revocation section on your copy of the form and returning it to this office.

Consent Section:

I, _____ (print name) hereby consent to the use and disclosure of my personal health information for the purpose of treatment, payment, and health care operations. I also understand and authorize this practice to use third party providers such as an outside billing company, a medical transcription company, and a clinical health data management company in the effort to provide care for me. My signature below indicates that I have been given an opportunity to read the Notice of Privacy Practices and to have any questions answered before signing.

I understand that I may request restrictions on the uses and disclosures of my health information at any time by completing and signing the restriction request section of this form. I further understand that the practice is not required to accept my restriction request.

I understand that I may revoke this consent at any time by signing the revocation section of my copy of this form and returning it to the practice. I further understand that any such a revocation does not apply to the extent that persons authorized to use of disclose my health information have already acted in reliance on this consent.

Patient Signature: x_____ Date: _____

My signature below acknowledges that I have been given a copy of the Notices of Privacy Practices.

Patient Signature: _____ Date: _____

Restriction Request Section:

Unless we have your permission to do so, we will not leave messages with anyone except the patient or legal guardian, leave messages on voicemail, or leave messages on an answering machine.

☐ YES ☐ NO Messages may be left on cellphone voicemail ☐ YES ☐ NO Messages may be left on home voicemail

Messages may be left with (Name and Relationship): _____

_____

_____

I request additional following restrictions on the uses and disclosures of my health information (please describe the restrictions in detail).

_____

_____

_____

Patient Signature: _____ Date: _____