

DALE R MYERS MD, P.C.

**CONSENT FOR USE AND DISCLOSURE OF
YOUR HEALTH INFORMATION**

With my consent the practice of Dale R Myers, M.D. P.C. may use and disclose my Protected Health Information to carry out my treatment, for obtaining payment, and to conduct its healthcare operations as outlined in the practice's Notice of Privacy Practices Form.

I have the right and responsibility to review the Notice of Privacy Practices Form prior to signing this consent. I am aware that the Notice of Privacy Practices Form may be revised by this office at anytime. Any such revision will be visible posted and made available to me at my request.

I have been advised to carefully review the list of rights that are available to me with respect to how this office will use and disclosed my Protected Health Information as outlined in their privacy policy. These rights include my right to request in writing certain restrictions on how the office uses and discloses my Protected Health Information.

I have the right to revoke this consent at any time. If I wish to do so I must do so in writing. By signing below I am acknowledging that I have read and understand this consent and the office's Notice of Privacy Practices Form. I further acknowledge that the office's Notice of Privacy Practice Form was readily available for me to read and take with me.

Signature of Patient

Signature of Legal Guardian

Print Patient's Name

Date