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PATIENT CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Patient Name _____ Birth Date: _____/_____/_____

Address:_____

_____

Telephone numbers: Home (_____) _____ Cell (____)_____ Work (_____) _____

Permission to Use and Disclose Your Health Information: By signing this consent, you authorize us to use and / or disclose your health information only for treatment, payment, or health care operations. You have the right not to sign this consent. However, if you refuse to sign this consent, we have the right to refuse to provide you services.

1. Your rights with respect to this consent:
   - **a.** Right to Review of Privacy Practices. You have the right to review a copy of our Notice of Privacy Practices before signing this consent. Our Notice of Privacy Practices details how we may use and disclose your health information. We may amend the Notice from time to time. You may obtain a copy of our Notice of Privacy Practices, including any revisions we have made, by calling the contact person for HIPAA compliance, **Tarrytown functional Medicine at (914) 631 – 7911.**
   - **b.** Right to Request Restrictions on Use / Disclosure. You have the right to request that we restrict how we use and / disclose your protected health information for the purpose of providing treatment, obtaining payment for our services, and / or conducting health care operations. Such requests MUST be in writing. Please note that we are not required to agree to any restriction you may request. If however, we decide to agree to a restriction you have requested, we must restrict our use and / or disclosure of your health information in the manner described in your request. To obtain a restriction request form, please call the Contact Person for HIPAA Compliance **(914) 631 – 7911** or visiting our website.
   - c. Right to Revoke Consent. You have the right to revoke this consent at any time. Your revocation of this consent MUST be in writing. If you wish to revoke the consent, please call the Contact Person for HIPAA Compliance at **(914) 631 – 7911** to obtain a revocation form. Note that you revocation of this consent will not be effective for disclosures we have already made if you revoke this consent.
   - d. Right to Receive a Copy of this Consent Form. You have a right to receive a copy of this consent form after you sign it.
2. Effective Period. This consent is effective unless and until you revoke it in writing.

I hereby authorize the health care professionals **TARRYTOWN FUNCTIONAL MEDICINE** to use and / disclose my health information for services, payment, or health care operation. I have read a copy of the notice of privacy practices and I understand the content.

X_____ Date: ___/___/___
Patient signature
Authorization of Personal Representative (e.g. health care power of attorney, guardian, other statutory authorization): _____