ARTHRITIS & RHEUMATIC CARE CENTER

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: Patient Giving Consent	
Name	
Address	
Telephone	Social Security
SECTION B: To the Patient - Plea	ase read the following statements carefully
	his form you will consent to our use and disclosure of your protected health payment activities, research and healthcare operations.
sign this consent. Our Notice provi- operations, of the uses and disclosu	ave the right to read our Notice of Privacy Practices before you decide whether to des a description of our treatment, payment activities, research and healthcare res we may make of your protected health information, and of other important information. A copy of our Notice accompanies this Consent. We encourage you before signing this Consent.
	rivacy practices as described in our Notice of Privacy Practices. If we change our vised Notice of Privacy Practices, which will contain the changes. Those changes ealth information that we maintain.
You may obtain a copy of our Noticentacting our office.	ice of Privacy Practices, including any revisions of our Notice, at any time by
to our office. Please understand that	right to revoke this Consent at any time by giving written notice of your revocation revocation of this Consent will not affect any action we took in reliance on this vocation, and that we may decline to treat you or to continue treating you if you
SIGNATURE	
this Consent form and your Notice of	have had full opportunity to read and consider the contents of frivacy Practices. I understand that, by signing this Consent form, I am giving re of my protected health information to carry out treatment, payment activities,
Signature:	Date:
If other than patient, relationship to	patient