THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of your health information.

Your signature on this consent will allow us to release information to, and receive information from, other health care providers for continuation of your health care. It will also allow you access to your own records from our facility without signing another consent. Your signature allows us to send your information via mail, fax or electronically.

Your signature acknowledges that you are aware of your privacy rights and that our facility (Britt A. Thedinger, MD, PC) "Notice of Information Practices Policy" has been made available to you.

Your Name or Child's Name if a minor (please print) _____

Your Signature _____

Relationship_____

Date_____

Consent to Release Information to:_____

- Spouse _____
- Other _____

Leave a message on my answering machine/voicemail:	☐ Yes	☐ No
Speak with a family member in my home about my care:	☐ Yes	☐ No
Speak with family member calling our office concerning my care:	☐ Yes	☐ No

This facility will not use or disclose your medical information in any other way unless you allow us to do so in writing. If you do give us permission to use or disclose your medical information for another purpose, you have the right to change your mind and revoke the permission at any time.