CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Your protected health information will be used by this practice, known as **LMG FAMILY PRACTICE P.C.** or disclosed to others for the purposes of treatment, obtaining payment or supporting the day-to-day health care operations of this practice.

We are providing you with a copy of our Notice of Privacy Practices. We request that you review the notice prior to signing this consent.

You may request a restriction on the use or disclosure of your protected health information. Please list any person or entity you would like for us to restrict your health information. ________________

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If we agree at your request your restrictions will be binding. Use and disclosure of protected information in violation of an agreed upon restriction will be a violation of federal privacy standards.

I request that the following family membes or significant others involved in my life be able to obtain the same health information about me as I would. (i.e. billing information, appointment making, appointment questions, referral requests, referral pick ups, prescription requests, prescription pick ups.) ____

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This practice reserves the right to modify the privacy practice outlined in the notice.

I understand that I have a right to revoke or change this authorization at any time I wish. I understand that I can do that by coming in person to the office or that written notice would be sent to Privacy Officer LMG Family Practice P.C. 1019 S Broad St Lansdale PA 19446. This information must include name, address, social security number, and the date of the request.

I have reviewed this consent form and have reviewed the Notice of Privacy Practices. I give my permission to this practice to use and disclose my health information in accordance with it.

______________________________ ______________________________

Printed Name Signature

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Relationship of person signing (if other than patient) Date