Elizabeth Pernal MD PA
813 A Eastern Shore Drive
Salisbury MD 21804
(410) 860-5151

Consent for Purposes of Treatment, Payment and Health Care Operations

Patient Name: _____ DOB: _____

Address: _____ SS#: _____

_____

Phone # (day):_____ Phone # (night):_____

I consent to the use and/or disclosure of my protected health information by Elizabeth Pernal MD PA for the purpose of diagnosing and/or providing treatment to me, obtaining payment for these services and/or to conduct the health care operations of Elizabeth Pernal MD PA.

I understand that the diagnosis and/or treatment of me by Elizabeth Pernal MD PA may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used and/or disclosed to carry out the treatment, payment and/or health care operations of the practice. Elizabeth Pernal MD PA is not required to agree to the restrictions that I may request. However, if Elizabeth Pernal MD PA agrees to a restriction that I request, the restriction is binding on Elizabeth Pernal MD PA.

I have the right to revoke this consent, in writing, at any time, except to the extent that Elizabeth Pernal MD PA has already taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Elizabeth Pernal MD PA's *Notice of Privacy Practices*, freely available at the office, prior to signing this document. The *Notice of Privacy Practices* describes the types of uses and/or disclosures of my protected health information that may occur in providing treatment to me, obtaining payment of my bills or in the performance of the health care operations of Elizabeth Pernal MD PA. The *Notice of Privacy Practices* also describes my rights and the duties of Elizabeth Pernal MD PA with respect to my protected health information.

Elizabeth Pernal MD PA reserves the right to change the privacy practices described in the *Notice of Privacy Practices* at any time. I may obtain a revised *Notice of Privacy Practices* by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Elizabeth Pernal MD PA's current *Notice of Privacy Practices* has been provided to me.

I consent to the use and/or disclosure of my protected health information as described above.

_____ _____
Signature of Patient Date