**Acknowledgement of Receipt of Notice of Privacy Practices**

I acknowledge that I have received and understand the Notice of Privacy Practices for this office.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

(If patient is a minor, parent or guardian must sign)

**Consent for Use and Disclosure of Health Information**

I hereby permit Essential Health, LLC., to release and furnish all medical and financial data related to my care that may be necessary now or in the future for purposes of treatment, payment or health operations to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to HMO’s and PPO’s managed care organizations, IPA’s, Medicare/Medicaid, or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

(If patient is a minor, parent or guardian must sign)

**You have the right to request that this office restrict uses and disclosures of your health information; however, this office is not required to agree to a requested restriction. You have the right to revoke this consent in writing, except to the extent that this office has previously taken action in reliance on this account. Your treatment by this office is conditional on your signing this consent.**

Please see our Privacy Practices for a more complete description. You will find this Notice of Privacy Practices in a notebook in our office. This Notice of Privacy Practices is also provided to you in your intake packet. If this consent is revised in the future, you may obtain a revised copy from this office.