CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I consent to the use or disclosure of my protected health information by Todd Guthrie, M.D., and/or Thomas Daniel, M.D., for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by the above 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 or disclosed to carry out treatment, payment or health care operations. Todd Guthrie, M.D. and/or Thomas Daniel, M.D., are not required to agree to the restrictions that I may request; however, if the above agree to a restriction that I request, the restriction is binding with the above.

I have the right to revoke this consent, in writing, at any time, except to the extent that the above has 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 the right to review the above physician's "Notice of Privacy Practices" prior to signing this document. The "Notice of Privacy Practices" describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations.

Upon your request, the "Notice of Privacy Practices" will be provided to you at the reception desk.

Todd Guthrie and Thomas Daniel reserve the right to change the privacy practices that are described in the "Notice of Privacy Practices".

SIGNATURE OF PATIENT OR REPRESENTATIVE

_____ DATE _____

NAME OF PATIENT OR REPRESENTATIVE (print)

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