DEANNA L. INLOW, DPM
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Tel (831) 373-3839 Fax (831) 373-0532

Patient Consent for Use & Disclosure of Protected Health Information

In signing this form, you consent to the use and disclosure of your protected health information by Dr. Deanna Inlow, our staff, and our business associates strictly for the purpose of treatment, payment and health care operations.

You acknowledge you have had an opportunity to review our ***Notice of Privacy Practices*** prior to signing this consent. We encourage you to review our ***Notice of Privacy Practices*** carefully. It provides more detail on how we may use and disclose your information. The ***Notice of Privacy Practices*** may change. A current copy may be required when you are being seen as a patient, by asking our receptionist at the front desk.

You may request that we restrict how we use and disclose your protected health information for the purposes mentioned above. If you would like to request a restriction, please do so in writing. However, we reserve the right to deny your request. If we grant your request, we are bound by the terms of the agreement.

You may also revoke this consent in writing; however, information on any treatment/service provided using this or prior consents may still be used or disclosed for purpose of treatment, payment and health care options.

_____

Signature of Patient or Co-Responsibility of party Date

_____

Print Name

Relationship to Patient/Legal Authority (*if applicable):*_____

FOR PRACTICE USE ONLY

Failure to obtain consent (check the appropriate reason):

☐ Indirect Treatment Relationship ☐ Emergency treatment

☐ Substantial Communication Barrier ☐ Refusal to sign ☐ Other

Description:_____

_____ _____

Practice Signature Date