

**CONSENT TO USE PROTECTED HEALTH INFORMATION & ACKNOWLEDGEMENT
OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

Instructions / Rights of Patient

1. Please read this Consent carefully and then sign below if you agree to its terms.
2. Do not sign this Consent until you understand the purpose and consequences of signing this Consent.
3. You may take a copy of this Consent with you to review it more closely prior to signing below.
4. Protected Health Information ("PHI") may be used or disclosed to carry out treatment, payment, or health care operations.
5. You have the right to read and inspect the Notice of Privacy Practices for this Health Care Facility prior to signing this form. The Notice of Privacy Practices may change at any time; therefore you should request and review a new Notice of Privacy practices if you have not done so recently.
6. You have the right to place restrictions on how your PHI may be used, or disclosed in the space provided below. However, please note that some restrictions may not be honored by this Health Care Facility. This Health Care Facility will be bound by such restrictions only if the Privacy Officer listed below declares such intent in a separate signed writing.
7. You have the right to revoke this Consent by sending a written notice, indicating the date and subject matter or other information that will reasonably identify this Consent, to the address printed at the bottom of this Consent. Such revocation will be effective only to the extent that this Health Care Facility had not relied on this Consent.

Consent for Release of Personal Health Information:

The undersigned patient ("Patient") or legally authorized representative ("Representative") of Patient hereby authorizes _____ ("Physician") to use or disclose the Patient's PHI to carry out treatment, payment, or health care operations on behalf of the Patient.

Limitations on Consent:

The Patient or Representative hereby requests that this Consent be limited to the following uses or disclosures of Patient's PHI:

I, the undersigned Patient or Representative, certify that I have read or otherwise understand this Consent and that I am legally competent to sign this authorization on behalf of myself or the Patient. I also acknowledge that I personally received a copy of the clinic's Notice of Privacy Policies.

(Authorized Signature)

____ / ____ / ____
(Date)

(Printed Name)

(Representative Capacity / Attach appropriate documentation)

*Folsom Orthopaedic Surgery &
Sports Injury Medical Clinic, Inc.
2575 East Bidwell St., Ste. 250
Folsom, CA 95630*