Michael L. Shelling, MD, LLC
Boynton Medical Arts Center
10075 S Jog Rd Suite #206 • Boynton Beach, FL 33437
Phone: (561)-737-1100 • Fax: (561)-731-4419

Consent for Use and Disclosure of Health Information

Section A: Patient Giving Consent

Name _____ Date of Birth _____

Address _____

Telephone_____ Social Security _____

Section B: Please read the following statements carefully.

Purpose of Consent: By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practice: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of the Notice posted for you to read. We encourage you to read it carefully and completely before signing the consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain these changes. Those changes may apply to any of our protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting: Michael L. Shelling, MD, 10075 S Jog Rd Suite #206, Boynton Beach, FL 33437. Phone: (561)-737-1100. Fax: (561)-731-4419.

Right to Revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of the Consent will not affect any action we took in reliance of this Consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this consent.

Acknowledgement: I have had an opportunity to review or read a copy of this office's Notice of Privacy Practices.

Signature: I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: _____ **Date:** _____

For Office Use: We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but this could not be obtained because: ___ individual refused to sign, ___ communication barriers prohibited obtaining acknowledgement, ___ an emergency situation prevented us from obtaining acknowledgment, ___ other.