

PATIENT CONSENT FORM

I understand that as part of my healthcare, Dr. Walter T. Sorokolit originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

Dr. Sorokolit's *Notice of Privacy Practices* provides specific information and complete description of how my personal health information may be used and disclosed. I understand that a copy of the *Notice of Privacy Practices* is available at the front desk and I understand that I have the right to review the notice prior to signing this consent. I understand that I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment or healthcare operations and that Dr. Sorokolit is not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that Dr. Sorokolit has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

We may change or policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen. You can request a paper copy of this notice, or any revised notice, at any time (even if you have allowed us to communicate with you electronically).

NOTE: Dr. Walter T. Sorokolit must obtain your written authorization to use your Private Health Information (PHI) for any purpose other than treatment or billing. If you want Dr. Sorokolit to have access to disclose your PHI to your spouse or any other person during your treatment, please sign below.

I agree to allow Dr. Walter T. Sorokolit to disclose my PHI (including date/time of appointments) to:

My Spouse _____
Print Name and Phone Number

Other Member(s) of my Family _____
Print Name and Phone Number

Other _____ (Print Name and Phone Number)

Myself only, no other family member

I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without by prior written authorization, except as other wise provided by law.

Signature of Patient or Legal Representative

Date

Print Name of Patient or Legal Representative