HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION
Your protected health information will be used by PREMIER Medical Group or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day healthcare operations of the practice.

THE NOTICE OF PRIVACY PRACTICES
PREMIER Medical Group is required to provide to you a notice that describes how information about you may be used and disclosed. Additionally, we must provide you information on how you may get access to this information. These policies and practices are defined in the “Notice of Privacy Policies and Practices” provided to you **PLEASE REVEW IT CAREFULLY.**

YOU MAY PLACE RESTRICTIONS ON THE USE OR DISCLOSURE OF YOUR HEALTH INFORMATION
You may request a restriction on the use or disclosure of your protected health information. However, PREMIER Medical Group may or may not agree to your request to restrict the use or disclosure of your protected health information see below. You may be asked to complete an authorization to activate this request. Please consult with a practice representative or the Office Manager if you would like additional information or clarification.

It is a violation of the federal privacy standards if PREMIER Medical Group agrees and fails to comply with your request. The restrictions requested will not affect use and disclosure of your information before the date of your request. If you still have questions after reviewing the Notice of Privacy Policies & Practices, please consult with a practice representative or the Office Manager at the location and contact information listed on the second page of the document.

YOU MAY REVOKE THIS CONSENT AT ANYTIME
You may revoke this consent at anytime; however, PREMIER Medical Group requires that you must revoke this consent in writing. If you choose to revoke this consent, the revocation will not affect use and disclosure of your information before the date of your request.

CHANGES TO PRIVACY PRACTICES
PREMIER Medical Group reserves the right to change or modify the privacy practices outlined in the Notice of Privacy Policies & Practices. PREMIER Medical Group will notify you of any changes of privacy practices either by mail, at your next appointment, or any other pre-approved method that you request.

SIGNATURE
I have reviewed this consent form, received the “Notice of Privacy Policies and Practices” and give my permission to PREMIER Medical Group to use and disclose my health information in accordance with this consent and the notice provided. What if they do not want their information shared with other providers, or with their insurance company? The new revised regs give patients the option to do that. Given if they opt out to insurance or government payer, they will assume responsibility . How long is this consent good for? Typically it is one year as a default in Connecticut.

______________________________ ______________________________
Name of Patient Signature of Patient/Date

If signed by the Authorized Representative, indicate your relationship to the patient below and provide a copy of the supporting documentation:

☐Parent ☐Guardian ☐Conservator ☐Executor of Estate ☐Power of Attorney ☐Other______________________

______________________________ ______________________________
Patient Representative Signature of Representative/Date

____________________________________ I suggest a witness signature.
Relationship of Patient to Representative