HIPAA (Health Insurance Portability Accountability Act) CONSENT

Diley Medical Group consent for disclosure of your Protected Health Information

Diley Medical Group will obtain and maintain protected health information (PHI) pertaining to you, a patient of our practice. Please be advised that we will use and disclose your PHI as necessary to treat you, receive payment for services and facilities provided to you, and for administration of health care operations. Our practice's ability to use and disclose a patient's PHI is more fully discussed in our NOTICE TO PATIENTS regarding Protected Health Information, which can be provided to you at your request and is posted in our waiting room. Prior to signing this consent, you have the right to review the NOTICE to PATIENTS regarding Protected Health Information and we will provide you with a copy of such Notice or make copies of such Notice available to you if it is materially amended in the future.

As a patient of Diley Medical Group you have the right to restrict our practice's use or disclosure of your PHI for carrying out treatment, payment, or health care operations; however, DIley Medical Group does not have to agree with such restrictions. Nevertheless, if we agree to your restrictions, we agree to be bound by such restrictions.

Unless Diley Medical Group has relied and acted upon your consent to use or disclose your PHI, you have the right to revoke this consent by providing our practice with a written revocation of consent.

If you should have questions regarding such consent, please contact the Privacy Officer of Diley Medical Group.

In accordance with Federal regulation and Diley Medical Group's "Privacy Policy" and "Privacy Procedures," the following has been implemented. At no time shall any person receive Protected Health Information (PHI) that pertains to any individual unless prior authorization has been completed.

I have read and understand this document and authorize the following person(s) to receive PHI in my absence to include, but not limited to: prescriptions, laboratory and radiology requests/ results, and medication samples. Please print names & relationship to patient.

1. Name_____ Phone number_____

   Relationship to patient _____
2. Name_____ Phone number_____

   Relationship to patient _____
3. Name_____ Phone number_____

   Relationship to patient _____
4. Name_____ Phone number_____

   Relationship to patient _____
5. Name_____ Phone number_____

   Relationship to patient _____

Print Patient's Name: _____ Date of Birth: _____

Patient Signature: _____ Effective Date: _____