Southlake Family Practice

CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, consent to the release of protected health information (PHI) by the Southlake Family Practice (SFP) that is required to carry out treatment, payment activities or healthcare operations on my behalf.

I have read the Notice of Privacy Practices and an aware of the following:

- I have the right to place restrictions on the way my protected health information is used or disclosed.
- I understand that SFP is not required to agree with my requested restrictions. I also understand that once SFP agrees to my restrictions, it must comply with those restrictions.
- I have a right to revoke my consent for the use and disclosure of my protected health information at any time. I understand that, if I choose to revoke my consent, I must submit a written statement to SFP that is signed by me.
- I understand that SFP must immediately comply with my request to revoke consent, except to the extent that SFP has already taken some action that was based on my original consent.
- SFP has reserved the right to change from time to time our privacy practices that are described in the Notice of Privacy Practices. Whenever we change our practices, we will modify the Notice accordingly; and will inform all patients via our website www.southlakefp.com and by posting the modifications and new Notice of Privacy Practices in each office waiting room.

Individual:	Witness:
_____	_____
Printed Name	Printed Name
_____	_____
Signature	Signature
_____	_____
Date	Date