Shah & Associates Family Practice, PA

431 Keisler, Dr. Suite 100,

Cary NC 27518
Phone: 919-468-6820 Fax: 919-468-6484

Consent to Use or Disclose Information for Treatment, Payment, Health Care Operations, or other Uses Permitted Under HIPAA

The Patient hereby consents to the use or disclosure of his/her individual, identifiable health information "protected health information" by Shah & Associates Family Practice, PA in order to carry out treatment, payment, or health care operations. The Patient should review our Notice of Information Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information, and the Patient has the right to review such Notice prior to signing this consent form.

Shah & Associates Family Practice, PA reserves the right to change the terms of its Notice of Information Practices for Protected Health Information at any time. If we do change the terms of the Notice of Information Practices, a copy of the revised notice will be mailed to you.

The Patient retains the right to request that Shah & Associates Family Practice, PA further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. Shah and Associates Family Practice is not required to agree to such requested restrictions; however, if we do not agree to the Patient's requested restrictions, such restrictions are then binding on Shah and Associates Family Practice, PA.

At all time, the Patient retains the right to revoke this Consent. Such revocation must be submitted to Shah and Associates Family Practice, PA in writing. The revocation shall be effective except to the extent that Shah and Associates Family Practice, PA has already taken action in reliance on the Consent.

Shah and Associates Family Practice, PA may refuse to treat the Patient if he/she (or an authorized representative) does not sign this Consent Form (except to the extent that the Facility is required by law to treat individuals). If the Patient (or authorized representative) signs this Consent Form and then revokes consent, Shah & Associates Family Practice, PA has the right to refuse to provide further treatment to the Patient as of the time of revocation (except to the extent that the Facility is required by law to treat individuals).

I have read and understand this information. I have received a copy of this form and I am the Patient or am authorized on behalf of the Patient to sign this document verifying consent to the above stated terms.

Date: _____ **Time: _____ AM / PM**

_____

Signature of Patient (or authorized Representative)

_____

Please Print Name of Patient

_____ *employee initial*