GREGG T. PODLESKI, D.O.

ORTHOPEDIC SURGERY • SPORTS MEDICINE • BOARD CERTIFIED

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CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION

PATIENT'S NAME ______________________________ DOB ______________________

Acknowledgement of Receipt of Privacy Notice

I, ____ acknowledge that I have received a Notice of Privacy Practices from Dr. Gregg T. Podleski. I give my consent to the use and disclosure of protected health information to carry out treatment, payment activities and health care operations only as explained in the Notice.

At this time I would like to give my consent for you to disclose personal health information to the following person(s) when necessary. This consent will remain in effect until further notice from me.

I give consent to disclose information about my **billing, insurance & appointment details only** to the following

NAME ____________________________________ RELATIONSHIP _________________

NAME ____________________________________ RELATIONSHIP _________________

I give consent to disclose information about my **medical condition** only to the following

NAME ____________________________________ RELATIONSHIP _________________

NAME ____________________________________ RELATIONSHIP _________________

SIGNATURE _____________________________________ **DATE** _________________

OTHER RESPONSIBLE PARTIES SIGNATURE ____________________________ **RELATIONSHIP TO PATIENT** ____________

Revised 1-3-2011