CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

1. This is to inform you the Marshall/Albion Medical Associates may use and disclose your health information that identifies you, and that consists of your past, present or future physical or mental health or condition, the provision of your health care; and the past, present, or future payment for the provision of your health care. The health information is referred to in the rest of this document as "Protected Health Information".

2. The use and disclosure of your Protected Health Information will be used to carry out treatment, payment, and health care operation of Marshall/Albion Medical Associates.

3. For a more complete description of how Marshall/Albion Medical Associates may use and disclose your Protected Health Information, and to find our the specific meanings of "treatment", "payment", and "health care operations", please refer to Marshall/Albion Medical Associates' Notice of Privacy Practices. You have a right to review the Notice of Privacy Practices prior to signing this Consent. The terms of the Notice of Privacy Practices may change from time-to-time; therefore, to obtain a revised Notice of Privacy Practices, please contact our business office.

4. You have the right to request that Marshall/Albion Medical Associates be restricted from using or disclosing your Protected Health Information in carrying out treatment, payment, or health care operations; however, Marshall/Albion Medical Associates is not required to agree to your requested restrictions. If Marshall/Albion Medical Associates does agree to your requested restrictions, then Marshall/Albion Medical Associates must comply with your request.

5. You have the right to revoke this consent, if you do so in writing, except to the extent that Marshall/Albion Medical Associates has taken action in reliance on this consent.

By signing this document, I acknowledge that I have read and understand this consent. Further, I hereby consent and authorize Marshall/Albion Medical Associates to use or disclose my Protected Health Information in conjunction with Marshall/Albion Medical Associates treatment, payment or health care operations in accordance with the terms of this consent.

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Signature (Patient) Date Signature (Authorized Representative) Date

_____ _____

Signature (Witness) Date Relationship to Patient

Reason Patient Unable to Sign_____

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