NAME:_____ ACCT #:_____

PLES L. KUJAWA, MD, PA
Notice of Privacy Practices Acknowledgment Form
Consent to Use or Disclose Protected Health Information

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information ("PHI") about you. You have the right to review our Notice before signing this form. You signature below acknowledges that you have received a copy of our **Notice of Privacy Practices**. As provided in our Notice, the terms of our Notice may change. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of PHI about you for treatment, payment and health care operations as described in our Notice. These disclosures may be by phone, mail, fax, or electronic transmission. **Unless you indicate otherwise in writing (by completing the form: Request for Restrictions on Use and Disclosure of Protected Health Information), if you allow a third party other than one of our practice's physicians or staff to be in the exam room while one of the physicians or staff is examining you or discussing your care, treatment or medical condition with you, by signing this Consent Form you are consenting to the disclosure of your PHI to that third party.** You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. If you refuse to sign this consent or revoke this consent, Ples L. Kujawa, MD, PA may refuse treatment or provide further treatment as of the time of the revocation, except to the extent that treatment is required by law.

I am consenting to the disclosure of my protected health information ("PHI") to the following individuals:

- Name_____ Relationship_____
- Name_____ Relationship_____
- Name_____ Relationship_____
- Name_____ Relationship_____
- Name_____ Relationship_____

I have read and understand the information in this acknowledgment. I am the patient or am authorized to act on behalf of the patient to sign this document.
By signing below, I acknowledge and agree to the above conditions.

Date_____

_____ _____
Signature of Patient or Authorized Representative Print Name of Patient or Authorized Representative*

**Please explain Representative's relationship to Patient and include a description of Representative's authority to act on behalf of Patient.*

_____

OFFICE USE ONLY: DATE_____ **ENTERED IN CLINICAL HISTORY by**_____