EUDORA MEDICAL

Today's date

Patient NAME	Date of birth

PRIVACY NOTICE
CONSENT TO RELEASE PROTECTED HEALTH INFORMATION

By signing below, I consent to the release of my Protected Health Information for the purpose of treatment, payment and health operation.

This is in compliance with our privacy policy, as outlined on our Privacy Notice available to you.

You have the right to review the privacy notice prior to signing this consent.

We reserve the right to change our privacy practices described in the notice and these changes will be reflected in an updated privacy notice.

You can obtain a copy of our most recent notice from our receptionist or office manager.

You have the right to request that Eudora Medical Center LLC restrict how your protected Health Information is used or disclosed to carry out treatment, payment and operation. However, Eudora Medical Center LLC is not required to agree to the requested restrictions.

You have the right to revoke this consent in writing at any time. This will be effective except to the extent that we have taken action in reliance of the consent.

I hereby agree to the conditions set above by Eudora Medical Center LLC and its policy outlined in the Privacy Notice.

I HAVE READ, UNDERSTOOD AND ACKNOWLEDGE RECEIPT OF THE EUDORA MEDICAL CENTER LLC PRIVACY NOTICE.

Signature **Date**

HIPPA

We will not share your medical information without your written permission. Please sign below as appropriate.

☐ Yes leave a text, message or voicemail Your signature

☐ Yes with spouse, name & # Your signature

☐ Yes with friend, name & # Your signature