A STATEMENT OF MY RIGHT TO HEALTH PRIVACY:

PLEASE PLACE COPIES IN MY MEDICAL AND BILLING RECORDS

I assert my right of consent as required in common law and the laws of this state. This right is based on traditional, medical ethics and principles expressed in the American Medical Association's Code of Medical Ethics.

I **do not** agree to any sharing or use of my or my family's health records without my permission.

Additionally, you must get my written permission to share any sensitive information, to the extent allowed by law, including:

Specific condition, disease, accident, or other information	*Initials of provider*

I opt out of all marketing. This includes marketing allowed by HIPAA such as communications related to treatment, case management, or care coordination.

I opt out of all research. You must tell me about a specific study and get my permission before using any of my information.

Contact me if you receive a subpoena requesting my or my family's health records. I have a right to look at the records selected before you share them to the extent allowed by law.

____ ________________

Patient signature Date

PROVIDER/PRIVACY OFFICER OR ADMINISTRATOR:

_____ I **agree** to disclose your health information only with your express consent and permission.

_____ I **do not agree** to obtain your express consent before disclosing your health information.

____ ________________

Treating provider (or privacy officer, administrator) signature Date

According to §164.522 of the Privacy Rule, a covered entity must permit an individual to request that the covered entity restrict uses and disclosures of protected health information.