

CONSENT FOR TREATMENT, PAYMENT and HEALTHCARE OPERATION

I consent to the use/or disclosure of any protected health information by Dr. Harry Pepe & Assoc., Inc. for the purpose of diagnosing or providing treatment, obtaining payment for healthcare services or staff, may be conditioned upon my consent as evidenced by my signature on the document.

My "Protected Health Information" means health information, including my demographic information collected from me and collected or received by my physician, another health care provider, a health plan, my employer, or a healthcare clearinghouse. The protected health information reasonably identifies me and related to my past, present, or future physical or mental health condition.

I understand that I have the right to request restrictions as to how my Protected Health Information is used or disclosed to carry out treatment, payment or healthcare operations to the practice. Dr. Harry Pepe & Assoc., Inc. its physicians and staff are not required to agree to the restrictions that I may request. However, if Dr. Harry Pepe & Assoc., Inc. its physician and staff members agree to a restriction that I request, the restriction is binding on Dr. Harry Pepe & Assoc., Inc. its physicians and staff.

I have the right to revoke this consent, in writing, at any time, except to the extent the Dr. Harry Pepe & Assoc., Inc. its physicians and staff have taken action in reliance on this consent. I understand that I have the right to review Dr. Harry Pepe & Assoc., Inc. Notice of Privacy Practices, which has been provided prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of healthcare operations of Dr. Harry Pepe & Assoc., Inc.

This notice of Privacy Practices also describes my rights and the duties of the physicians and staff of Dr. Harry Pepe & Assoc., Inc. with respect to my protected health information. Dr. Harry Pepe & Assoc., Inc., reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

Signature of Patient/Personal Representative

Date

PRINTED name of Patient or Personal Representative

Relationship to Patient