HIPAA Consent Form

Use and Disclosure of Your Protected Health Information

Your protected health information will be used by Drs. Donald Conway, David Humphreys, James McDonough, and Colette Stern, or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day to day health care operations of the practice.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information.

Drs. Donald Conway, David Humphreys, James McDonough, and Colette Stern, may or may not agree to restrict the use or disclosure of your protected health information

If Drs. Donald Conway, David Humphreys, James McDonough, and Colette Stern agree to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent o the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

Drs. Donald Conway, David Humphreys, James McDonough, and Colette Stern reserve the right to modify the privacy practices outlined in the notice.

Signatures

I have reviewed this consent form and give my permission to Drs. Donald Conway, David Humphreys, James McDonough, and Colette Stern to use and disclose my health information in accordance with it.

James M. McDonough
____
Name of patient (Print or Type)

____________________________	____________________________
Signature of Patient	Signature of Patient Representative (if patient is a minor or unable to consent)
__________________	____________________________
Date	Relationship to Patient