A STATEMENT OF MY RIGHT TO MEDICAL PRIVACY

PLEASE PLACE COPIES IN MY MEDICAL AND BILLING RECORDS

I assert my right of consent as codified in common law, the laws of this state, and in the traditional ethical principles governing medical privacy embodied in the American Medical Association's Code of Medical Ethics, I do not agree to any disclosures of any part of my medical records or my family's medical records without my specific consent.

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Patient signature

Date________________

Please indicate below whether you agree or refuse to obtain my express consent before disclosing my health information or my family's health information.

____ I agree to disclose your health information only with your express consent.

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

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Treating Provider (or privacy officer, administrator)

Date__________________________