Brad K. Greenspan, MD

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Consent for Release and Use of Protected Health Information (PHI)
and
Receipt of Notice of Privacy Practices Form

I, ____________________________________, hereby give my consent to Dr. Greenspan to use
Name of Patient or Authorized Agent
or disclose, for the purpose of carrying out treatment, payment, or health case operations, all information contained in the patient record of ________________________________.
Patient's Name

I acknowledge receipt of Dr. Greenspan's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information regarding how the practice may use and disclose my confidential information.

I understand that Dr. Greenspan has reserved the right to change his privacy practices which are described in the Notice.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notices of my desire to do so to the office of Dr. Greenspan. I also understand that I will not be able to revoke this consent in cases where Dr. Greenspan has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the office of Dr. Brad Greenspan and is valid upon receipt.

Signed:______________________________ Date:_________________________

If you are not the patient, please specify your relationship to the patient:__________________