Partners in Health Healing Arts Center
Dr. Heather Fliege, M.D.
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**Consent to Use and Disclose Protected Health Information**

**USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION**

Your protected health information will be used by Heather Fliege, MD, or disclosed to others, for the purpose of treatment or supporting the day to day health care operations of this 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 DICLOSURE OF YOUR INFO**

You may request a restriction on the use or disclosure of your protected health information. If Heather Fliege, MD agrees to your request, the restriction will be binding of 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 to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use of disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

**RESERVATION OF THE RIGHT TO CHANGES PRIVACY PRACTICES**

Heather Fliege, MD reserves the right to modify the privacy practices outlines in the notice.

**CONSENT AND SIGNATURE**

I have reviewed this consent form and give my permission to Heather Fliege, MD to use and disclose my health information in accordance with it.

____________________________________
Name of Patient (Print or Type)

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Date

____________________________________
Signature of Patient or Patient Representative

____________________________________
Relationship to Patient

Persons Authorized to Have Access To My Medical Records:
____________________________________________
____________________________________________
____________________________________________