LOUISVILLE CONCIERGE MEDICINE, PLLC

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CONSENT FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

As required by the Health Insurance Portability and Accountability Act of 1996 this practice may not use your personal health information for the purposes of treatment, payment or health care operations. The specific uses and disclosures that we intend to make are described in our Notice of Information Practices. You have the right to review restrictions on the uses and disclosures described in the notice of information practices by describing the requested restrictions in the "restriction request" section of this form. You may revoke this consent at any time by signing and dating the revocation section on your copy of the form and returning it to this office.

CONSENT SECTION

I, _____ (print name) hereby consent to the use and disclosure of my personal health information for the purpose of treatment, payment and health care operations. My signature below indicates that I have been given an opportunity to read the Notice of Information Practices and to have any questions answered before signing.

I understand that I may request restrictions on the uses and disclosures of my health information at any time by completing and signing the restriction request section of this form. I further understand that the practice is not required to accept my restriction request.

I understand that I may revoke this consent at any time by signing the revocation section of my copy of this form and returning it to the practice. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this consent.

_____   _____
         Signature   **Date**

My Signature below acknowledges that I have been given a copy of the Notices of Privacy Practices.

_____   _____
         Signature   **Date**

RESTRICTION REQUEST SECTION

I hereby request the following restrictions on the uses and disclosures of my health information (please describe the requested restrictions in detail):

_____
_____
_____

_____   _____
         Signature   **Date**