Dr. Daniel Cameron and Associates
Daniel J. Cameron, M.D., M.P.H., P.C
657 Main Street, Mt. Kisco, NY 10549
Phone: 914-666-4665 Fax: 914-666-6271

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

NAME: _____

ADDRESS: _____

TELEPHONE: _____ EMAIL: _____

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:

PURPOSE OF CONSENT: By signing this form you will consent to our use and disclosure of protected health information to carry out treatment, payment activities, and health care operations. The office will continue to require additional consent in writing to give out your medical records.

NOTICE OF PRIVACY PRACTICES: You have the right to read our notice of privacy practices before you decide whether to sign this consent. Our notice provides the description of our treatment, payment activities, and health care operations, of the use and disclosures we may make of your protected health information, and of other important matters about protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our notice of privacy practices. If we change our privacy practices, we will issue a revised notice of privacy practices, which will contain the changes. Those changes may apply to any of your protected health information that we have maintained.

You may obtain a copy of our notice of privacy practices, including any revisions of our notice, at any time by contacting the following:

CONTACT PERSON: Daniel J. Cameron, M.D., M.P.H.
Address: 657 Main Street, Mount Kisco, NY 10549 **Telephone #:** (914) 666-4665 Fax: (914) 666-6271

RIGHT TO REVOKE: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitting to the contact person listed above. Please understand that revocation of this consent will not affect any actual retake and reliance of this consent before we receive your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

Please initial if you want us to leave voice mail or send via email regarding your lab result: ☐

I, _____have had full opportunity to read and consider the contents of this consent form and your notice of privacy practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: _____ Date: _____

If this consent is signed by personnel representative on behalf of the patient, complete the following.

PERSONNEL REPRESENTATIVE'S NAME: _____

RELATIONSHIP TO PATIENT: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.