Valley Family
& Procedural Medicine

Consent for Release and Use of Confidential Information
and Acknowledgement of Notice of Privacy Practices

I, _____hereby give my consent to Valley Family and
(Name of Patient or Authorized Agent)

Procedural Medicine to use or disclose, for the purposes of carrying out treatment, payment, or health care operations, all information contained in my private health record.

I acknowledge the review and/or receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information. I understand that the physician has reserved a right to change his or her privacy practices that are described in this Notice. I also understand that a copy of any revised Notice will be available to me upon a written request to the Privacy Officer.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this Notice at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office

I understand that I have the right to request that the practice restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment, or health operations. I understand that the practice does not have to agree to such restrictions, but that once such restrictions are agreed to, the practice and their agents must adhere to such restrictions.

Due to the HIPPA Privacy Act, we are not permitted to release information regarding your care. If you wish to grant your permission, please list below the person(s) that we may speak with on your behalf. Please be aware those listed below will be given full access to your Private Health Information.

(1)_____ _____
Name Relationship to Patient

(2)_____ _____
Name Relationship to Patient

Signed:_____ Date:_____

If not the Patient, please specify your relationship to the patient:_____