Name: _____

Date of Birth: _____

Consent

I give Dr. Joseph Tutor's office my consent to use or disclose my protected health information to carry out my treatment to obtain payment from insurance companies, and for other health care providers.

I have been informed that I may review the practice Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my personal restrictions, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for the information already disclosed.

Confirm Appointment At:

Home: _____
Work: _____
Cell: _____

Can leave detailed message At:

Home: _____
Work: _____
Cell: _____

Whom can we discuss treatment with other than yourself:

_____

Signature: _____Date:_____
Patient, parent or legal guardian

If signed by patient representative, state relationship to patient _____