Darrell Belcher, Philip Branson, Robert Kropac, & Frederick Morgan
PATIENT INFORMATION CONSENT FORM

I have been informed that the Notice of Patient Information Practices is posted in the lobby and in the examination rooms of Darrell Belcher, Philip Branson, Robert Kropac, & Frederick Morgan. I have been offered a copy from Darrell Belcher, Philip Branson, Robert Kropac, & Frederick Morgan's Notice of Information Practices. I understand that Darrell Belcher, Philip Branson, Robert Kropac, or Frederick Morgan (whichever is my treating physician) may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Darrell Belcher, Philip Branson, Robert Kropac, or Frederick Morgan will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Darrell Belcher, Philip Branson, Robert Kropac, and Frederick Morgan's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____
Patient Name

_____
Signature

_____
Date

I also authorize Darrell Belcher, Philip Branson, Robert Kropac, or Frederick Morgan (whichever is my treating physician) to use my protected health information for targeted marketing, fund raising, and/or solicitation of participation in research studies. I understand that I have the right to copy or inspect any information used for these purposes. I also understand this authorization does not affect my consent to use my protected health information for treatment, billing, or operations related to treatment and billing.

_____
Patient Name

_____
Signature

_____
Date