PATIENT CONSENT FORM

Cannon Physician Practices

Please Note: If you have received this form by mail, please bring it with you to your next appointment. Thank you.

Our *Notice of Privacy Practices* provides information about how we may use and disclose protected health information about you and your rights with respect to your health information. You have the right to review our notice before signing this consent. As stated in our notice, the terms may change. If we change our notice, you may obtain a revised copy by requesting one from the front desk personnel. The revised notice will also be posted in our waiting room.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize the taking of my photograph for the sole purpose of the providers and staff at Cannon Memorial Hospital. Cannon Memorial Hospital will only use this photograph to assist in patient identification and as part of the medical record. As such, the use and privacy of the photo retains full protection under HIPAA policy.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you also acknowledge that you have received or reviewed a copy of the *Notice of Privacy Practices.*

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SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

____
PRINTED NAME OF PATIENT OR PERSONAL REPRESENTATIVE

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RELATIONSHIP TO THE PATIENT (if applicable)

____
DATE

FOR OFFICE USE: Office copy, place in patient's record