Patient Consent for Use and Disclosure of Protected Health Information

Please sign this form to consent to our disclosures of you medical information in order to provide you with proper treatment.

Patient's Full Name: ____Date of Birth: __________________

I hereby authorize **Bloomfield Hand Specialists**, to use and/or disclose my protected health information in connection with my treatment, payment, and health care operations.

Patient Signature: ____Date: ________________________

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Parent or Guardian (if patient is a minor) (Please Print)

Signature of Parent or Guardian: ____________________________________Date: _______________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OR OUR PRIVACY POLICY:

Please sign this form below to acknowledge that you have received a copy of our privacy policy.

____Date: _______________________

Patient Signature:

____Relationship: __________________

Parent or Guardian if patient is a minor (Please Print)

____Date:_______________________

Signature of Parent or Guardian

* PATIENT REFUSED TO SIGN THE ACKNOWLEDGEMENT: (DUE TO THE FOLLOWING REASONS)

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Office Personnel Signature: ____Date:______________________