CONSENT OF DISCLOSURE

(For the Usage and/or Disclosure of Protected Health information)

I hereby give consent to Dr. Rigney and staff and all health care providers furnishing care to Myself________________________________(First and Last Name) to use and disclose my Protected health information for the purposes of treatment, payment and health care Operations.

Our Posted Privacy Policy provides more detailed information about usage and Disclosure of your protected health information. You have the right to review our Posted Privacy Policy before you sign this consent.

Print Name of Patient:____________________________________

Sign:________________________Date:______________________

We will not share any information with any other entity, other than your insurance company(s) your Primary Care Physician, and/or a Physician we refer you to.