Michael Wein, M.D., P.A.

PROTECTED HEALTH INFORMATION CONSENT

I hereby give consent to the office of Dr. Michael Wein to use and disclose my protected health information for the purposes of treatment, payment and health care operations.

My protected health information consists of health information, including my demographic information, whether received by me, another physician or health care provider, insurance carrier, my employer or a health care clearinghouse. This may also include prescription history information. This protected health information relates to my past, present or future health/condition(s) and identifies me.

Our Notice of Privacy Practices provides more detailed information about how we may use and disclose your protected health information. A copy our Notice of Privacy Practices is available upon request before signing this consent. Our practice reserves the right to change the terms of our Notice of Privacy Practices.

You may revoke this consent at any time. This must be in writing and signed by you or on your behalf.

Sign: ____ Date: __________________

Print name of patient: ____

If you are signing as the patient's representative:
Print your name: ____
Relationship: ____