Cary HealthCare Associates, P.A.

Consent to Use or Disclose Information
For Treatment, Payment, Health Care Operation, or other Uses Permitted Under HIPAA

The Patient hereby consents to the use or disclosure of his/her individually identifiable health information ("protected health information") by Cary Healthcare Associates, P.A. in order to carry out treatment, payment, or health care operations. The Patient should review our Notice of Information Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information, and the Patient has the right to review such Notice prior to signing this consent form.

Cary Healthcare Associates, P.A. reserves the right to change the terms of its Notice of Information Practices for Protected Health Information at any time. If we do change the terms of the Notice of Information Practices, a copy of the revised Notice will be mailed to you.

Patient retains the right to request that Cary Healthcare Associates, P.A. further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. Cary Healthcare is not required to agree to such requested restrictions; however, if we do not agree to the Patient's requested restrictions, such restrictions are then binding on Cary Healthcare Associates, P.A.

At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to Cary Healthcare Associates, P.A. in writing. The revocation shall be effective except to the extent that Cary healthcare Associates, P.A. has already taken action in reliance on the Consent.

Cary Healthcare Associates, P.A. may refuse to treat Patient if he/she (or an authorized representative) does not sign this Consent Form (except to the extent that the Facility is required by law to treat individuals). If Patient (or authorized representative signs this Consent Form and then revokes Consent, Cary Healthcare Associates has the right to refuse to provide further treatment to Patient as of the time of revocation (except to the extent that the Facility is required by law to treat individuals).

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATES TERMS.

Date: ________________ Time: ________ AM / PM

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Signature of Patient (or authorized Representative)

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Please Print Name