



CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

I hereby authorize Robert Sikora, M.D. to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Robert Sikora, M.D. can refuse to treat me.

I have been informed that Robert Sikora, M.D. has prepared a notice ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying Robert Sikora, M.D. in writing, but if I revoke my consent, such revocation will not affect any actions that Robert Sikora M.D. took before receiving my revocation.

I understand that Robert Sikroa, M.D. has reserved the right to change his privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that Robert Sikora, M.D. restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that Robert Sikora, M.D. does not have to agree to such restrictions, but that once such restrictions are agreed to, Robert Sikora M.D. must adhere to such restrictions.

Signature of patient/patient's parent – representative-guardian

Date

Printed Name of patient/patient's parent-representative-guardian

Relationship to patient