Patient Consent/Acknowledgement Form

Dr. Sein H. Siao and Associates

Patient Name: _____

By signing below, you consent to the use and disclosure of your protected health information by Dr. Sein H. Siao, our staff, and our business associates for treatment, payment and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Information Practices ("Notice"). You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revise Notice by simply contacting this office at 508/384-8136 and requesting a revised Notice. We will also post any revised notice in the office.

You have the right to request that we restrict our uses or disclosures of your protected health information that we are otherwise permitted to make for treatment, payment, and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you may refuse to consent to the use of disclosure of your protected health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Protected Health Information (PHI).

In addition to the authorization for release of my PHI described above, I authorize disclosure of information regarding my billing, condition, treatment, and prognosis to the following individual(s):

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

This form is also used to obtain acknowledgement of receipt of OUR NOTICE of privacy practices or to document our good faith effort to obtain that acknowledgement.

I have reviewed, understand, and agree to the content of the notice of privacy.

Signature _____ Date _____

Please specify the exact reason why patient chose not to sign the consent/ACKNOWLEDGEMENT of notice of privacy.