VIGI, LLC

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

I, , hereby authorize **VIGI, LLC** to use and/ or disclose my health information which specifically identifies me or which can be reasonably 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, **VIGI, LLC** can refuse to treat me.

I have been informed that **VIGI, LLC** 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 **VIGI, LLC** in writing, but if I revoke my consent, such revocation will not affect any actions that **VIGI, LLC** took before receiving my revocation.

I understand that **VIGI, LLC** has reserved the right to change its privacy practices and that I can obtain such changed notice upon request.

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

Signature of patient or patient's representative **Date**

Printed name of patient or patient's representative

Relationship to the patient