Glenn Marron, PhD PLLC
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CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

PATIENT: _____ DATE:_____

In connection with the medical services that I am receiving from the practice of Glenn Marron, PhD PLLC , I hereby authorize this office to disclose any/or all information concerning my medical condition and treatment, including copies of applicable hospital and medical records, to :

A. Any third party payer covering my medical services;
B. Other health care professionals and institutions involved in the delivery of health care to me;
C. The proponent of any legally sufficient subpoena, or in response to a court order;
D. Employees and agents of the practice, to the degree necessary to facilitate the provision of health care services and payment for such services;
E. Pharmacies;
F. Other parties as otherwise required by law;

In each case, the practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above. I further understand that I have read the physician's privacy notice and that I have had the opportunity to place special restrictions upon the consent hereby given:

Special Restrictions:

_____

_____

This consent is valid from the date executed until revoked in writing by me.

Signed: _____ Date:_____

Witness:_____

PRIVACY NOTICE

In accordance with the Health Insurance Portability and Accountability Act of 1996, patients of this practice are entitled to the greatest degree of privacy possible. This office will strive to ensure that patient information is used only for authorized purposes as agreed to by the patient.

Patients are advised that they have a right to review their medical files upon reasonable notice to the practice and during normal business hours, and to make comments to the same.