Ketchum, Wood & Burgert, chtd. d/b/a

Pathology Associates
Patient Consent for Disclosure of Health Care Information

Patient's name: _____ Date of birth: _____

SSN: _____ Previous name: _____

I understand that the patient's health information is private and confidential. I understand that Pathology Associates is committed to protecting the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Pathology Associates may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. I understand that sometimes the law may permit the release of this information without my permission.

Pathology Associates has a detailed document called the "Notice of Privacy Practices". A copy of this document may be found at the Reception desk and on-line at www.kwbpathology.com. This document contains more information about the policies and practices protecting the patient's privacy. I understand that I have the right to read the "Notice of Privacy Practices" before signing this agreement.

Pathology Associates may update the "Notice of Privacy Practices." If I ask, Pathology Associates will provide me with the most current "Notice of Privacy Practices."

Under the terms of this consent, I may ask Pathology Associates to limit how the patient's personal health information is used or disclosed to carry out treatment, payment or health care operations. I understand that Pathology Associates does not have to agree to my request. If Pathology Associates does agree to my request, I understand that Pathology Associates will adhere to the agreed upon limits of disclosure.

I may cancel this consent in writing at any time by doing one of the following:

1) Signing a form that Pathology Associates can give me called "Revocation of Consent/Authorization…"

2) Writing, signing, and dating a letter to Pathology Associates. If I write a letter, it must say that I want to revoke my consent to authorize the use and disclosure of the patient's personal health information for treatment, payment, and health care operations.

If I revoke this consent, Pathology Associates is not required to provide further health care services to the patient.

My signature below indicates:

(Please initial)

_____ I have been given the opportunity to review Pathology Associates' "Notice of Privacy Practices".
_____ I agree to allow Pathology Associates to use and disclose the patient's personal health information to carry out treatment, payment, and health care operations.

_____ _____ _____
Patient or legally authorized individual signature Date Time

_____
Relationship to patient, if signed by anyone other than the patient
(parent, legal guardian, personal representative, etc.)