Midland Family Physicians, P.C.
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

1) This is to inform you that Midland Family Physicians, P.C. may use and disclose your health information that identifies you, and that consists of your past, present or future physical or mental health or condition, for the provision of your health care; and the past, present or future payment for the provision of your health care (this health information is referred to herein as "Protected Health Information").
2) The use and disclosure of your Protected Health Information will be to carry out treatment, payment and health care operations of Midland Family Physicians, P.C.
3) For a more complete description of how Midland Family Physicians, P.C. may use and disclose your Protected Health Information, and to find out the specific meanings of "treatment," "payment" and "health care operations", please refer to the Midland Family Physicians Notice of Privacy Practices. You have the right to review the Notice of Privacy Practices prior to signing this consent. The terms of the Notice of Privacy Practices may change from time-to-time; therefore, to obtain a revised Notice of Revised Privacy Practices, please contact:

   Midland Family Physicians
   920 W. Wackerly Street
   Midland, MI 48640
   Attn: Nancy Davis

4) You have the right to request that Midland Family Physicians be restricted from using or disclosing your Protected Health Information in carrying out treatment, payment, or health care operations; however, Midland Family Physicians is not required to agree to your requested restrictions. If Midland Family Physicians does agree to your requested restrictions, then Midland Family Physicians must comply with your request.
5) You have the right to revoke this Consent, if you do so in writing, except to the extent that Midland Family Physicians has taken action in reliance on this Consent.

By signing this document, I acknowledge that I have read and understand this Consent. Further, I hereby Consent and authorize Midland Family Physicians to use or disclose my Protected Health Information in conjunction with Midland Family Physicians treatment, payment or health care operations in accordance with the terms of this Consent.

Signature_____ Date _____