Bonnie Zucker & Associates, PC
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Rockville, MD 20852
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CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This form is an agreement between you, _____ and us, Bonnie Zucker & Associates, PC. When we use the words "you" and "your" below, this can mean you, your child, your relative, or some other person if you have written his or her name here: _____.

When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment (e.g., with insurance companies), to help carry out certain business or government functions, or to help provide other treatment for you.

By signing this form, you are agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

If you do not sign this form agreeing to my privacy practices, we cannot treat you (or your child if your child is the patient). In the future, we may change how we use and share your information, and so we may change my notice of privacy practices. If we do change it, we will give you the revised practices.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. Please provide this information in writing. Although we will try to respect your wishes, we are not required to accept these limitations. After you have signed this consent, you have the right to revoke it by written request.

_____ _____
Signature of client or his/her personal representative Date

_____ _____
Printed name of client or representative Relation to client