EVERYDAY HEALTH CARE

199 W SHIELDS AVE
FRESNO CA, 93705
(559)225-4706 FAX (559)225-4710

PATIENT CONSENT FORM

By signing this form you are granting consent to Everyday Health Care to use and disclose your protected health information (PHI) for the purpose of treatment, payment, and health care operations. Our Notice of privacy Practices provides more detailed information about how we may use and disclose this protected Practice before you sign this consent, and we encourage you to read it in full.

Our Notice of privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our facility at (559) 225-4706.

You have the right to request us to restrict how we use and disclose your protected health information (PHI) for the purpose of treatment, payment, or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement. If you refuse to sign this consent, or revoke this consent, Everyday Health Care may refuse to treat you as permitted by section 164.506 of the code of Federal Regulations.

You have the right to revoke this consent in writing, except to the extent we already have used, or disclosed your protected health information (PHI) in reliance on your consent.

Patient signature/ Guardian Date

Printed Name of Patient/Guardian Date