PATIENT CONSENT FOR DISCLOSURE OF MEDICAL INFORMATION

Please take a moment to read this abbreviated version of Dr. Banki's privacy policy. If you would like our complete four page HIPAA privacy policies to take home, please indicate by initialing here _____.

With my consent, Dr. Banki may call my home or other designated location and leave a message on voice mail or with another person in reference to any items that assist the practice in carrying out my treatment, payment or healthcare operations. This may be done with regard to appointment confirmation or scheduling, insurance issues, account information or clinical care.

With my consent, Dr. Banki may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment or healthcare operations, such as appointment reminder cards, patient statements or medical information.

By signing this form, I am consenting to Dr. Banki the use and disclosure of my medical information to carry out my treatment, payment or healthcare operations. If I do not sign this consent, Dr. Banki may decline to provide treatment to me.

_____ _____

Name of Patient Date

_____

Signature of Patient, POA or Legal Guardian (if under the age of 18)

For established minors without a parent or legal guardian at the time of service:
I acknowledge I have received a copy of Dr. Banki's Notice of Privacy Practices and this consent form for my parent or legal guardian's signature. This form is to be returned to Dr. Banki.

_____ _____

Signature Date