DIX-EUREKA MED CENTER

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Family Medicine & Urgent Care
S.R. Kaura, M.D. / Jane Johnson, M.D.

PATIENT CONSENT

With your consent, we may use and disclose protected health information about you to carry out treatment, payment, or healthcare operations. Please review our Notice of Privacy Practices for a more complete description of such uses and disclosures. You may request a copy of it. You may review the notice prior to signing this consent. We reserve the right to change our Privacy Practice Policy.

You may request that we restrict how we use or disclose your protected health information to carry out treatment, payment, or health operations. We are not required to agree to the requested restrictions. If we do agree to a requested restriction, the restriction is binding on us.

By signing this form, you consent to our using and disclosing your protected health information to carry out treatment, payment, or health care operations. You may revoke this consent in writing, except to the extent that we have acted in reliance on your prior consent.

If you decline to this consent, we may decline to provide treatment to you. This consent is valid through April 15, 2023.

Signature X _____ *Witness X* _____

Print Patient Name X _____ *Date* _____