PATIENT CONSENT FORM

By signing this form, you are granting consent to **Cedar Hill Primary Care, LLC** ("Provider") to use and disclose your protected health information for the purpose of treatment, payment and health care operations. This Notice of Privacy Practices provides detailed information about how we may use and disclose this protected health information. Protected health information is individually identifiable information relating to a patient's health, to the healthcare treatment for the patient or for payment for healthcare.

You have a legal right to review our Notice of Privacy Practices ("Notice") before you sign this consent, and you are encouraged to read it in full. The Notice may be subject to change. If we change our Notice, you may obtain a copy of the revised Notice from our office staff.

You have a right to request that we restrict how we use and disclose your protected health information for purposes other than treatment, payment or health care operations. However, as your healthcare provider we are not necessarily required by law to grant your request and may by law refuse to provide non-emergency treatment if the restriction on the use and disclosure is not acceptable. However, if we do grant your request, we are bound by that agreement.

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

Signature:_____Date_____

For Office Use:

Received by:_____ Date:_____