1200 East Davis Street, suit 113
Mesquite Tx, 75149

Phone: (972)295-9090
Fax: 972-534-0010

Consent and acknowledgement of Receipt of Privacy Notice

I understand that as part of provision of healthcare service, Pioneer Healthcare Clinic, creates and maintains health record and other information describing among other thigh, my health history symptom, diagnosis, treatment, examination and test results, prescription drug history, and any plans for future care or treatment.

I have been provided with a notice of privacy practice that provides a more complete description of the use and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of revised notice to the address I have provided. I understand that I have the right to request restriction as to how my information may be used or disclosed to carry out treatment, payment or healthcare operation (Quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restriction requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purpose of treatment, payment and healthcare operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, where written or oral or in electronic format, are confidential and cannot be discussed for reasons outside of treatment, payment or healthcare operation without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as the original
3. I have the right to request that the use of my protected health information, which is or disclosed for the purposes of treatment, payment or healthcare operations, be restricted. I also understand that Pioneer Healthcare Clinic and I must agree to any restriction in writing that I requested on the use and disclosure of my protected health information, and agree to terminate any restriction I writing on the use and disclosure of my Protected information which have been previously agreed upon.

______________________ Full Name	________________ Date:
______________________ Signature	________________ Date of Birth
______________________ Guardian's Signature (if child)	