Language for Consent/Acknowledgment

Use and Disclosure of Protected Health Information

I understand that William A Hamilton, MD may use and disclose my protected health information for purposes of treatment, payment and health care operations. I also acknowledge that I have received, have been offered, or have received a copy of the Practice's Notice of Privacy Practices, which provides information about how the Practice and individuals involved in the Practice, may use and disclose my protected health information. As provided in the Notice, the terms of the Notice may change. To obtain a copy of any current Notice, I understand that I can contact the Privacy Officer at (540-373-4700).

I understand that I have the right to request that the Practice restrict how my protected health information is used or disclosed for treatment, payment or health care operations, but I also understand that the Practice is not required to agree to a requested restriction. However, if the Practice does agree, it is bound by that agreement. I understand that I have the right to revoke this consent in writing at any time, except to the extent that the Practice, or individuals involved in my care in the Practice, have already used or disclosed protected health information in reliance on my prior consent.

_____	_____	_____
Patient or Legal Surrogate	Date	Relationship to Patient

_____	_____
Witness	Date