AUTHORIZATION TO RELEASE OR USE INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

I hereby authorize the release or use of my protected health information ("PHI") and medical record information by the Rice Diet Program ("the Practice") in order to carry out treatment, payment, or health care operations. These disclosures may be by phone, mail, fax, or electronic transmission. You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent form.

If you allow a third party other than one of our practice's physicians or staff to be in the exam room while one of our physicians or staff is examining you or discussing your care, treatment or medical condition with you, by signing this Consent form you are consenting to the disclosure of your PHI to that third party.

We reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised Notice.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or health care operations. Our practice is not required to agree to such requested restrictions: however, if we do agree to your requested restriction(s), such restrictions are then binding on the practice.

I acknowledge and agree that the Practice may disclose my protected health Information and medical record information to the following individuals (please initial on line and write in name of individual):

_____ Spouse ____________________________
_____ Child ____________________________
_____ Other ____________________________
_____ Parent ____________________________
_____ Legal Guardian ____________________
_____ Other ____________________________

I agree that the Practice may also disclose the following types of information contained in my medical record (please initial the appropriate categories listed below):

_____ HIV/AIDS Information
_____ Mental Health Information
_____ Substance Abuse Information
_____ Sexually Transmitted Disease Information
_____ If Patient is under the age of eighteen (18), Pregnancy Information

I agree and consent to the Practice releasing information to me in the following alternative manners (please initial the appropriate spaces below):

_____ Via regular mail
_____ Via telephone
_____ Via fax to my designated fax number which is: ______________________________
_____ Via hone answering machine
_____ Via work voice mail