



4709 W Parker Rd, #440 Plano, TX 75075 972-398-0440

Acknowledgment of Notice of Privacy Practices
Consent to the Use and Disclosure of PHI

Notice of Privacy Practices

I am aware of the “Notice of Privacy Practices” in this office. I understand that it details how my protected health information may be used or disclosed. I understand it details my rights and privileges as a patient. I realize that I may review the Notice prior to signing this consent, and that I am entitled to my own copy of this Notice upon request.

Use and Disclosure of Protected Health Information

I understand that it is necessary for Genesis Regeneration Centers to maintain records describing my demographic and health information for the purpose of treatment, obtaining payment, and supporting day-to-day health care operations.

I understand that it is mandatory by law for this office to obtain my signed authorization to release or obtain certain information.

Genesis Regeneration Centers is bound by law to safeguard the use and disclosure of my protected health information, and such policies are detailed in the Notice.

Right to Change Notice

I further understand that *Genesis Regeneration Centers* reserves the right to modify the privacy practices outlined in the Notice, and I am entitled to updated versions as they become available.

I have reviewed this consent form and give my permission to *Genesis Regeneration Centers* to use and disclose my protected health information in accordance with it.

PRINT Patient Name

Date

Signature of Patient (or Representative)

Relationship of Patient Representative

Office Representative

Date