CHARLOTTE B. ALEXANDER, M.D., P.A.

Consent for Purposes of Treatment, Payment and Healthcare Operations

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I consent to the use or disclosure of my protected health information by Charlotte B. Alexander, MD for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Charlotte B. Alexander MD. I understand that diagnosis or treatment of me by my physician may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Charlotte B. Alexander MD is not required to agree to the restriction that I may request. However, if Charlotte B. Alexander MD agrees to a restriction that I request, the restriction is binding upon Charlotte B. Alexander MD.

I have the right to revoke this consent, in writing, at any time, except to the extent that my physician has taken action in reliance on this consent.

My "Protected health information" means health information, including my demographic information, collected from me and created or received by Charlotte Alexander, MD., another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information related to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information my identify me.

I understand I have a right to review Charlotte B Alexander MD Notice of Privacy Practices prior to signing this document. The notice has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Charlotte B. Alexander MD.

Charlotte B. Alexander MD reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment

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Signature of Patient or Personal Representative **Date**

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Name of Patient or Personal Representative **Description of Personal Rep Authority**