

# MAIN LINE RHEUMATOLOGY

CONSENT TO USE

AND

DISCLOSE PROTECTED HEALTH INFORMATION

Your protected health information will be used by this practice, known as GARY V.GORDON, MD, THOMAS P. HARDER, MD and AMY L. LUNDHOLM, D.O. and CHARLES MOLTA, M.D. or disclosed to others for the purposes of treatment, obtaining payments or supporting the day to day healthcare operations of this practice.

You may request a restriction on the use or disclosure of your protected health information. If you should wish to restrict your disclosure, you should make the request in writing.

This practice, however, may or may not agree to restrict the disclosure of your protected health information.

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date of your revocation of consent is received will not be affected.

This practice reserves the right to modify the privacy practices outlines in this notice.

I have reviewed this consent form and have reviewed the Notice of Privacy Practices. I give my permission to this practice to use and disclose my health information in accordance with it.

NAME OF PATIENT (PRINT CLEARLY)

SIGNATURE OF PATIENT

---

ADDITIONAL NAME TO DISCLOSE INFORMATION

RELATIONSHIP

---

DATE