AUTHORIZATION TO RELEASE OR USE INFORMATION FOR TREATMENT, PATIENT OF HEALTH CARE OPTIONS

I hereby authorize the release or use of my protected heath information ("PHI") and medical record information by Clifford P. Clark III, M.D. ("the Practice") in order to carry out treatment, payment or health care options. These disclosures may be done by mail, phone, fax or electronic transmission.

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

I acknowledge and agree that the Practice may disclose my PHI (protected health information) and medical record information to the following individuals.

_____

_____

_____

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 (address): _____

_____ Via home answering machine: _____

_____ Via my cellular phone: _____

_____ Via my e-mail address: _____

_____ Via work voice mail: _____

At all times, you retain the right to revoke this consent. Such revocation must be submitted to the Practice **in writing**. The revocation shall be effective except to the extent that the Practice has already taken action based on your prior Consent.

The Practice may refuse to treat you if you (or an authorized representative) do not sign this Consent Form. If you (or authorized representative) sign this Consent and then revoke it, the Practice has the right to refuse to provide further treatment to you as of the time of revocation (except to the extent that the Practice is required by law to treat individuals)

I have read and understand the information in this consent.

By signing below, I acknowledge and agree to the above conditions.

_____ _____

Signature of Patient or Authorized Representative Date

If Representative, explain relationship to patient _____