KATE BLUMNER MD, LLC

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Consent of Disclosure

(for the usage and/or disclosure of Protected Health Information)

I hereby give consent to Kate Blumner MD, LLC to use and disclose my protected health information for the purposes of treatment, payment and health care operations. By signing this form, you are also agreeing to let me use your Protected Health Information and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

You may cancel this consent at any time. Your cancellation must be in writing, signed by your on your behalf and delivered to the address at the top of this form. This consent may be delivered in person or by mail. It will only be effective when I actually receive it. Your cancellation will not be effective to the extent that others or I have acted in reliance about this consent.

You have the right to request restrictions on the usage and disclosure of your protected health information for the purposes of treatment, payment or healthcare operations. I am not required to grant your request; however, if I do, the restrictions will be obligatory to me.

My posted privacy policy provides more detailed information about the usage and disclosure of your protected health information. You have the right to review my posted privacy policy before you sign this consent.

I reserve the right to amend the terms of my posted privacy policy. You may obtain a copy of the current policy by requesting a copy from me.

Printed Name of Patient: _____

Signature _____

Date: _____