PATIENT CONSENT FORM

Regarding the Use & Disclosure of Health Information

Required by Federal Law

I understand that some of my health information may be used and/or disclosed by Red River Family Practice to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures, I should refer to your privacy notice entitled, "notice of Privacy Practices". I understand that I may review this privacy notice any time prior to signing this form.

I understand that over time your privacy practices may need to change in accordance with law, and if I wish to obtain a copy of the notice as revised, I can call your office to request such a copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment or health care operations, and that I can also revoke this consent in writing but only to the extent that your practice has not taken action in reliance thereon.

I understand that for my protection, my requests to amend my health information or to access my medical records must be made in writing.

_____________________________________ Date:______________________________

Signature