John M. Moore, MD
17300 PRESTON RD, STE 160
DALLAS, TX 75252
972-867-9135

Consent to the Use and Disclosure of Health Information

Name_____ DOB_____

I understand that I have rights regarding my protected health information. These rights are governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I have been informed of, and given the opportunity to review and secure a copy of John M. Moore, MD Notice of Privacy Practices, which contains a complete description of the uses and disclosure of my protected health information.

I understand that The Notice of Privacy Practices information serves as:

- A basis for planning my care and treatment.
- A means of communication amongst the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations, such as assessing care quality and reviewing the competence of healthcare professionals.

I authorize my medical information to be discussed with and/or disclosed to:

☐ **Patient** _____ ☐ **Physician** _____

☐ **Family member or friend** _____ ☐ **Other** _____

Detailed messages regarding test results can be left on answering machine or voicemail:

☐ **Yes** ☐ **No** **Phone #**_____

*☐ **Do not disclose medical information**

I acknowledge that I have been provided an opportunity to review the Notice of Privacy Practices for John Moore, MD.

_____ _____

Signature of Patient or Legal Representative Date