Consent for the Use and Disclosure of Protected Health Information

By signing below, or by electronic signature, you consent to the use and disclosure of your protected health information by Miller Prosthetics & Orthotics, LLC, our staff, and our business associates for treatment, payment and health care operations purposes. For a more detailed description of our uses and disclosures of protected health information, please review our Notice of information Practices (“Notice"), which you acknowledge receiving on this date. You have the right to review our Notice prior to signing this consent.

The terms of thìs Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting us at (304) 699-2373 or 1-800-754-1878 and requesting a revised Notice.

You have the right to request that we restrict our uses or disclosures of your protected health information that we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you have the right to revoke the consent in writing, except to the extent that we have taken action in reliance on it.

Please sign below, or by electronic signature, stating that you have read, understand and acknowledged the above information regarding your consent for the use and disclosure of protected health information.

_____ _____

Patient/Guardian Signature Date

_____

Patient Name

Signatures are digitally captured in OPIE HIPAA Patient Documents & Supplier Standards