CONSENT OF DISCLOSURE

I herby give consent to Dr. Radu Wolf's Office and all health care providers furnishing care within Dr. Wolf's office to use and disclose my protected health information for the purposes of treatment, payment and health care operations.

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

You have the right to request restriction on the usage of your protected health operations. We are not required to grant your request, however, if we do, the restriction will be obligatory to us.

Our Posted Privacy Policy provides more detailed information about usage and disclosure of your protected health information. You have the right to review our Posted Privacy Policy before you sign this consent.

We reserve the right to amend the terms of our Posted Privacy Policy. You may obtain a copy of the current policy.

Print Name of Patient:_____

Signature of Patient: _____ Date: _____

If you are signing as the patient's representative:

Print your Name: _____

Relationship: _____

CANCELLATION

I herby void the consent given above.

Print Name of Patient:_____

Signature of Patient:_____ Date: _____

Relationship: _____

Print your Name: _____

Address for cancellation (your cancellation will be effective, upon receipt, at the mentioned address):

_____

_____