***** OFFICE POLICY*****

Acct: #_____

I consent to the use or disclosure of my **Protected Health Information (PHI)** by VEL@NEV for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of VEL@NEV. I have the right to revoke this consent, in writing, at any time, except to the extent that VEL@NEV has taken action in reliance on this consent.

My **"Protected Health Information"(PHI)** means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Print Name of Patient or Personal Representative Date