WILLIAM EARL FOX, M.D.

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Suite 335

Charlottesville, VA 22911

PATIENT CONSENT TO THE USE OF PROECTED HEALTH INFORMATION

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that my private health information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this office has the right to change its Notice of Privacy Practices from time to time and that I may contact this office at any time at 675 Peter Jefferson Parkway, Suite 335, Charlottesville Virginia 22911 to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restriction.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this content.

Patent Name (PRINT): _____

Patient Name (SIGNATURE): _____ Date: _____