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CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION

I consent to the release of protected health information that is required to carry out treatment, payment and/or healthcare operations on my behalf.

I have read the Notice of Privacy Practices and am aware of the following:

- I have the right to place restrictions on the way my protected health information is used or disclosed.
- I understand that PRIMO is **not** required to agree with my requested restrictions. I also understand that once PRIMO agrees to my restrictions, it must comply with those restrictions.
- I have a right to revoke my consent for the use and disclosure of my protected health information at any time. I understand that, if I choose to revoke my consent, I must submit a written statement that is signed by me.
- I understand that PRIMO must immediately comply with my request to revoke consent, except to the extent that it has already taken some action that was based on my original consent.
- I understand that PRIMO must immediately comply with my request to revoke consent, except to the extent that it has already taken some action that was based on my original consent.

PRIMO has reserved the right to change from time to time our privacy practices that are described in the Notice of Privacy Practices. Whenever we change our practices, we will modify the Notice accordingly; and we will inform you by posting a copy of the revised Notice in the waiting area.

Printed Name: ___________________________

Signature: ______________________________

Date: __________________________________