Alancia C. Wynn, M.D.
Wynn Family Medicine
8316 Arlington Blvd., #234
Fairfax, Va. 22031

Consent for the use and disclosure of Protected Health Information

Patient_____ Date:_____

Address:_____

Parent/Guardian(if under 18):_____

Relationship to Patient:_____

Purpose of consent-I am giving consent to Alancia C. Wynn, M.D. to use and disclose protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices-I have the right to read the Notice of Privacy Practices before I decide whether to sign this consent. The notice provides a description of the manner in which we may use and disclose your protected health information.

I reserve the right to revoke this consent at any time by giving a written notification and we may decline to treat or continue to treat if you revoke this consent.

Protected health information may be released to the following (spouse, children, etc)

1._____

2._____

Protected health information may be released to other covered entities for use in treatment, payment activities and healthcare operations.

I understand that I have a right to inspect and obtain copies of protected healthcare information. (In accordance with federal privacy regulations 45CFI 164.524)
I understand that I do not have to sign this consent and that my refusal to sign will not affect my eligibility for benefits.
I have the right to obtain a copy of this consent form.

_____ _____

signature(parent/legal guardian) Date