PLEASE READ CAREFULLY!

Protected Health information may be disclosed to insurance companies, managed care organizations or referring physicians in the course of treatment, payment of healthcare operations. When information is disclosed to another entity, it may be subject to redisclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule. You have the right to refuse or restrict our disclosure of your information. However, if you refuse or restrict disclosure, we will be unable to provide treatment to you. If you wish to refuse or restrict disclosure, please ask for a HIPAA Restriction form.

You have the right to determine how we may communicate with you concerning your treatment or payment for services. Please indicate below where we may leave messages for you.

I consent that Dawn L. Shogren M.D, P.A. may contact me by:

Please check all that apply

- ❑ Telephone at home
- ❑ Leave message on answering machine at home
- ❑ Telephone at work
- ❑ Leave message with a person or on voice mail at work
- ❑ Leave message on cellular phone or at any other number I provide
- ❑ Email: _____@ _____. com net

I consent that Dawn L. Shogren, M.D., P.A. may discuss or disclose information regarding my clinical care and/or financial history with those listed here:

_____ _____
Name Relationship to patient

_____ _____
Name Relationship to patient

This consent will expire on January 1, 2023.

_____ _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN Date

I acknowledge that I have been given an opportunity to read and understand Dawn L. Shogren, M.D., P.A.'s Notice of Privacy Practices.

_____
Name of Patient

_____ _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN Date

You may revoke this consent in writing except to the extent that the practice has already made disclosures in reliance upon your prior consent. If you do not sign this consent, Dawn L. Shogren, M.D., P.A. may decline to provide you treatment.