Consent of Disclosure

(For the Usage and/or Disclosure of Protected Health Information)

_____________________________________ , hereby give consent to Dr. Stephen Matarazzo to use and disclose my protected health information for the purposes of treatment, payment and heaithcare operations.

You may cancel this consent at anytime. Your cancellation must be in writing, signed by you or on your behalf, and delivered to the address at the bottom of this form. This may be delivered in person or by mail, but it will only be effective when we actually receive it. Your cancellation Will not be effective to the extent that we or others have acted in reliance upon this consent.

You have the right to request restriction on the usage and disclosure of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to grant your request, however, if we do, the restriction will be obligatory to us.

Our Posted Privacy Policy provides more detailed information about the usage and disclosure of your protected health information. You have the right to review our Posted Privacy Policy prior to signing this consent.

We reserve the right to ammend the terms of our Posted Privacy Policy.

CONSENT

Patient Name ____

Sign____Date ________________________

If you are signing as the patient representative:

Print your Name ____

Relationship to Patient ____

CANCELLATION OF CONSENT

1, hereby, void the consent given above.

Patient Name ____

If you are signing as the patient representative:

Print your Name ____

Relationship to Patient ____

Address for cancellation, which will be effective upon receipt at the following address:
Stephen J. Matarazzo, D.M.D., P.0
300 Crown Colony Drive
Quincy, MA 02169