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USES AND DISCLOSURES UNDER HIPAA

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by **Stanley B Pollak, M.D.** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct of health care operations of **Stanley B Pollak, M.D.**

I have the right to revoke this consent, in writing, at any time, except to the extent that **Stanley B Pollak, M.D.** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority