

Consent to Use and Disclose Protected Health Information

I hereby consent to the use and disclosure of my protected health information by Dr. Catherine Gurski for the purposes of treatment, payment and healthcare options, or as otherwise required by law.

A Notice of Privacy Practices, which provides more detailed information about the usage and disclosure of my protected health information, is available. I have the right to review the Notice prior to signing this consent and to receive a printed copy of the Notice.

- I have the right to request restrictions to the usage and disclosure of my protected health information.
- I have the right to request an alternative to the standard method of communication of my protected health information.
- I have the right to revoke this consent, in writing, at any time. Revocations will be honored as the date that they are received by Dr. Gurski at the address below:
1962 NW Kearney, Suite 102
Portland, OR 97209
503-274-4360

I understand that while Dr. Gurski may honor these requests, they are not required by law to do so. I am also aware that Dr. Gurski reserves the right to change the terms of the Notice of Privacy Practices and to make new Notice of Privacy Practice for my review.

Patient Signature/Guardian

Date

Patient Printed Name

As a courtesy, it is the clinic policy to call or text a reminder message of your appointment a day or two in advance. If you prefer not to receive a reminder call or text please let us know. If a reminder is not received, you are still responsible for your appointment and a \$50 fee will be assessed for missed appointments without a 24 hours cancellation notice except for emergencies such as natural disasters, hospitalization or sudden death of a family member.