DELAWARE FAMILY CARE ASSOCIATES
2700 Silverside Road, Suite 2
Wilmington, De 19810

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to use or disclosure of my protected health information by **Delaware Family Care Associates** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Delaware Family Care Associates**. I understand that diagnosis or treatment of me by **Jeffrey P. Cramer, M.D. and Kristine B. Diehl, M.D.,** may be conditioned upon my consent as evidenced by my signature on this document

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Delaware Family Care **Associates** is not required to agree to the restrictions that I may request. However, if **Delaware Family Care Associates** agrees to a restriction that I request, the restriction is binding on **Delaware Family Care Associates and Jeffrey P. Cramer, M.D. and Kristine B. Diehl, M.D.**

I have the right to revoke this consent, in writing, at any time, except to the extent that **Jeffrey P. Cramer, M.D. and Kristine B. Diehl, M.D or Delaware Family Care Associates** 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 health care clearinghouse. This protected health information relates to may 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.

I understand I have a right to review **Delaware Family Care Associates** Notice of Privacy Practices prior to signing this document. The **Delaware Family Care Associates** Notice of Privacy practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the **Delaware Family Care Associates**. The Notice of Privacy Practice for Delaware Family Care Associates is also provided at our front desk and on **Jeffrey P. Cramer, M.D and Kristine B. Diehl M.D’s** web site www.delawarefamilycare.com. This notice of Privacy Practices also describes my rights and the **Delaware Family Care Associates** duties with respect to my protected health information.

Delaware Family Care Associates reserves the right to change the privacy practices that are described in Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the **Delaware Family Care Associates** website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my appointment.

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Signature of Patient or Personal Representative

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Name of Patient or Personal Representative

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Date

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Description of Personal Representative’s Authority