Frank J. Farrell, M.D.
2186 Geary Boulevard, Suite 320
San Francisco, California 94115
(415) 749-6900

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I, ____, hereby authorize Dr. Farrell to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Dr. Farrell can refuse to treat me.

I have received a copy of the Notice of Privacy Practices ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations.

I understand that I may revoke this consent at any time by notifying Dr. Farrell, in writing, but if I revoke my consent, such revocation will not affect any actions that Dr. Farrell took before receiving my revocation.

I understand that Dr. Farrell has reserved the right to change his privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that Dr. Farrell restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that Dr. Farrell does not have to agree to such restrictions, but that once such restrictions are agreed to, Dr. Farrell must adhere to such restrictions.

____ ____________________________
Signature of patient or patient's representative Date

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Printed name of patient or patient's representative

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Relationship to the patient