Consent for Use and Disclosure

Of Health Information

I hereby permit Premier Wellness Internal Medicine, LLC Michelle Sun, M.D., P.A., and Catheryne Zavodny, M.D., P.A.) to release and furnish all medical and financial data related to my care that may be necessary now or in the future for purposes of treatment, payment or health care operations to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMO's and PPO's, managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payors, or any organization contracting with any of the above entities to perform such functions.

Patient Signature ____

Date Signed ____

You have the right to request that this office restrict uses and disclosures of your health information; however, this office is not required to agree to a requested restriction. You have the right to revoke this consent in writing, except to the extent that this office has previously taken action in reliance on this consent. Your treatment by this office is conditional upon your signing this consent.

Please see our Notice of Privacy Practices for a more complete description. You may review our Notice of Privacy Practices prior to signing this consent. If this consent is revised in the future, you may obtain a revised copy from the Front Office.