

**Model Consent for Release and Use of Confidential  
Information and Receipt of Notice of Privacy Practices Form**

I, \_\_\_\_\_  
( Name of Patient or Authorized Agent),  
hereby give my consent to **Bright Light Radiology** to use or disclose, for the  
purpose of  
carrying out treatment, payment, or health care operations, all information  
contained in the patient record of \_\_\_\_\_  
(Patient's Name).

I acknowledge receipt of the physician's Notice of Privacy Practices. ***The  
Notice of Privacy Practice provides detailed information about how the  
practice may use and disclose my confidential information.***

I understand that the physician has reserved a right to change his or her  
privacy practices that are described in the Notice. I also understand that a  
copy of any Revised Notice will be provided to me or made available to me on  
my next office visit.

I understand that this consent is valid until it is revoked by me. I understand  
that I may revoke this consent at any time by giving written notice of my  
desire to do so, to the physician. I also understand that I will not be able to  
revoke this consent in cases where the physician has already relied on it to  
use or disclose my health information. Written revocation of consent must be  
sent to the physician's office.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

If you are not the patient, please specify your relationship to the patient.