Katy Sheridan MD
154 W Marydale Ave
Soldotna, AK 99669

Patient Consent for Use and Disclosure Of Protected Health Information

I hereby give my consent for Dr Sheridan's practice to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

I have the right to review the Notice of Privacy Practices prior to signing this consent. The providers listed above reserve the right to revise its Notice of Privacy Practices at any time. A revised notice may be obtained by forwarding a written request to 245 N Binkley St Ste 203 Soldotna, AK 99669.

With this consent, the practice may email or call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as patient statements, appointment reminders, insurance items and all calls pertaining to my clinical care, including laboratory test results, among others.

I have the right to request that the above practice restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow the above practice to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, the above practice may decline to provide treatment to me.

Signature of Patient or Legal Guardian:

Print Patient's or Legal Guardian's Name: Date:

Signature of Witness

Revised 9/2008