DALLAS EYE & EAR

LINDA L. BURK, MD

CONSENT

TO THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, HEALTH CARE OPERATIONS, AND AS OTHERWISE ALLOWED BY LAW

Linda L. Burk, MD will maintain a record of the care and services you receive at our office. This consent only covers your protected health information created while you are a patient of Linda L. Burk, MD. Your protected health information pertains to your diagnosis and/or treatment at Linda L. Burk, MD, including but not limited to information concerning mental illness (except for psychotherapy notes), use of alcohol or drugs or communicable diseases such as Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS), laboratory test results, medical history, treatment progress or any other such related information.

By signing this form, you consent to Linda L. Burk, MD's use and/or disclosure of protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. Our *Notice of Privacy* Practices provides information about how Linda L. Burk, MD may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. **By signing this form, you also acknowledge that you have received a copy of Linda L. Burk, MD's *Notice of Privacy Practices* and an opportunity to review it before signing this consent.**

_____ _____

Signature of Patient or Legal Representative Witness

_____

Date

HIPPAA Authorization: I authorize the following person(s) to discuss my medical care and billing/insurance information with Linda L. Burk, MD staff on my behalf:

Name:_____ Relationship:_____

Name:_____ Relationship:_____