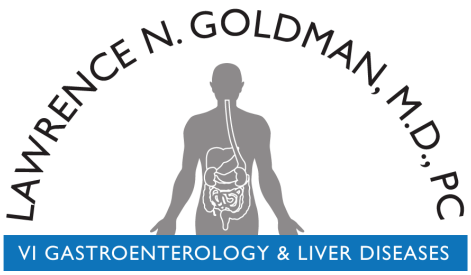


P.O. Box 7988, St. Thomas, USVI 00801
340-714-1122

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

I, _____, hereby authorize **Lawrence N. Goldman, MD PC** to use and/or disclose my health information which specifically identifies me or which can be reasonably 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, **Lawrence N. Goldman, MD PC** can refuse to treat me.

I have been informed that **Lawrence N. Goldman, MD PC** has prepared a notice ("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 have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying **Lawrence N. Goldman MD PC** in writing, but if I revoke my consent, such revocation will not affect any actions that **Lawrence N. Goldman MD PC** took before receiving my revocation.

I understand that **Lawrence N. Goldman, MD PC** 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 **Lawrence N. Goldman, MD PC** restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that **Lawrence N. Goldman, MD PC** does not have to agree to such restrictions, but that once such restrictions are agreed to, **Lawrence N. Goldman, MD PC** must adhere to the restrictions.

_____ _____
Signature of patient or patient's representative Date

_____
Printed name of patient or patient's representative

_____
Relationship to the patient