



**PATIENT CONSENT**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

By signing this consent you are giving the providers and office staff permission to use and disclose your health information. Your health information will be used and disclosed to provide your care and treatment, to bill and collect payment for the services provided, and to perform necessary routine office operations.

You have been provided with a copy of our “Notice of Privacy Practices” that contains a complete description of the uses and disclosures covered under this consent. You have been given time to review the “Notice of Privacy Practices” and we have encouraged you to read it and ask any questions that you may have prior to signing this consent.

Our office reserves the right to change the privacy practices as stated in the “Notice of Privacy Practices”. You will be given a copy of the revised notice with your first office visit following any change. The most current notice is prominently posted in our waiting room and you may request a copy at any time.

You have the right to request that we restrict how your health information is used or disclosed. We are not required to agree to your requested restriction, but if we do agree to the restriction, we will honor the restriction.

You have the right to revoke this consent except to the extent that we have already taken action covered under the consent. If you choose to revoke this consent, you must do so in writing.

This consent must be signed by the patient and dated.

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Relationship if Not Patient

\_\_\_\_\_  
Date

*A copy of our Privacy Act is available upon request*

Donald J. Digby, M.D.P.A.  
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