RALEIGH ENDOCRINE ASSOCIATES

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

I hereby consent to the use or disclosure of my identifiable health information ("protected health information") by Raleigh Endocrine Associates in order to carry out treatment, payment, or health care operations. I have been given the opportunity to review Raleigh Endocrine Associates Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information. I have the right to review such Notice prior to signing this consent form.

Raleigh Endocrine Associates reserves for itself the right to change the terms of this Notice of Privacy Practices for Protected Health Information at any time. If Raleigh Endocrine Associates does change the terms of it's Notice of Privacy Practices, you may obtain a copy of the revised Notice by requesting the Notice from the Front Office Staff of Raleigh Endocrine Associates.

I retain the right to request that Raleigh Endocrine Associates further restrict how my protected health information is used or disclosed to carry out treatment, payment, or health care operations. Raleigh Endocrine Associates is not required to agree to such requested restrictions; however, if Raleigh Endocrine Associates does agree to my requested restriction(s), such restriction(s) are then binding on Raleigh Endocrine Associates.

At all times, I retain the right to revoke this Consent. Such revocation must be submitted to Raleigh Endocrine Associates in writing. The revocation shall be effective except to the extent that the Raleigh Endocrine Associates has already taken action in reliance on the Consent. Raleigh Endocrine Associates may refuse to treat you if you do not sign this Consent Form (except to the extent Raleigh Endocrine Associates is required by law to treat individuals). If you (or authorized representative) sign this Consent Form and then revoke consent, then Raleigh Endocrine Associates has the right to refuse to provide further treatment to you as of the time of revocation (except to the extent that the Facility is required by law to treat individuals).

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT, OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS SEALED DOCUMENT VERIFYING CONCENTER TO THE ABOVE STATED TERMS.

_____	____/____/_____	_____AM/PM
PRINT NAME	Today's Date	Time
_____	___/____/_____	_____
SIGNATURE	DATE OF BIRTH	WITNESS