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In compliance with the federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPPA), Drs. Rodman and Engelstein have established privacy policies and procedures relating to the protected health information of our patients.

By signing this form, you are granting consent to Drs. Rodman and Engelstein to use and disclose your protected health information for the purposes of treatment, payment and health care operations. A copy of our Notice of Privacy Practices, which provides more detailed information about how we may use and disclose this protected health information, will be provided to you at your request.

I agree that the Practice, Drs. Rodman & Engelstein, may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

You have the right to revoke this consent in writing, except where we have already made disclosures in trust on your prior consent.

X_____ _____

Signature **Date**

_____

Print Name