DR. LAUREN GERBER
CONSENT FOR RELEASE AND USE OF CONFIDENTIAL INFORMATION

I, ____, hereby give my
Patient or Guardian
consent to Dr. Lauren Gerber to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of ____________________________.
Patient

I understand that this Consent is valid until it is revoked by me. I also understand that Dr. Gerber reserves the right to change her privacy practices that are described in the Notice. I also understand that a copy of any revised notice will be provided to me or made available at my request.

Patient Signature
and/or Guardian: ______________________________________

Date: ______________________________________