Tega Cay Psychiatric Associates, PA

Medical Consent Form

I _____, hereby authorize Gina Hartmeier, MD to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out me treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Gina Hartmeier, MD and associates can refuse to treat me.

I have been informed that Gina Hartmeier, MD 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 Gina Hartmeier, MD has reserved the right to change her privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that Gina Hartmeier, MD restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that Gina Hartmeier, MD does not have to agree to such restrictions are agreed to, Gina Hartmeier, MD must adhere to such restrictions.

_____ _____

Signature of patient or patient's representative Date

_____

Printed name of patient or patient's representative

_____

Relationship to the patient