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**PATIENT CONSENT FOR USE AND DISCLOSURE OF  
PROTECTED HEALTH INFORMATION  
(HIPAA)**

With my consent, Dinesen & Associates may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). I have the right to review Dinesen & Associates Notice of Privacy Practices prior to signing this consent for a more complete description of such uses and disclosures.

Healthcare professionals, including doctors, nurses, and technicians, in the Doylestown Clinical Network may access your demographic information for the purpose of providing your care.

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**Signature of Patient or Legally Authorized Representative** **Date**

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**Print Name of Patient of Birth** **Date**

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**Print Name of Legally Authorized Representative** **Relationship to Patient (e.g., Parent, Guardian)**