

Exhibit B

PATIENT CONSENT FORM

I understand that as part of my healthcare, Leslie S. Welborne, M.D. and/or, Melissa Bailey M.D., ("PHYSICIAN") originates and maintains health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

The PHYSICIAN's Notice of Privacy Practices provides specific information and complete description of how my personal health information may be used and disclosed. I have been provided a copy of or access to the Notice of Privacy Practices and understand that I have the right to review the notice prior to signing this consent. I understand that the PHYSICIAN reserves the right to change the Notice of Privacy Practices. Prior to implementation of the revised Notice of Privacy Practices, the revised Notice will be mailed to me if I provide my address below. I understand that I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment or healthcare operations and that the PHYSICIAN is not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that the PHYSICIAN has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

I request the following restrictions on the use and/or disclosure of my personal health information.

I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as other wise provided by law.

I have been provided and have reviewed the PHYSICIAN's Notice of Privacy Practices dated _____

Signature of Patient or Legal Representative

Date

Print Name of Patient or Legal Representative

*I request that changes to the Notice of Privacy Practices be sent to me at this address:
