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Patient's Name: _____ Date of Birth: _____

Consent for Use and Disclose of Health Information for Treatment, Payment, and/ or Healthcare Operations

I,_____,understand that as a part of my health care, this practice originates and maintains paper, and / electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information as:

1. A basis for planning my care and treatment
2. A means of communication among the many health professionals who contribute to my care
3. A source of information for applying my diagnosis and surgical information to my bill
4. A means by which a third-party payer can verify that services billed were actually provided
5. A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Privacy Policy that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

1. The right to review the notice prior to signing this content
2. The right to object to the use of my health information for directory purposes
3. The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that this practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, expect to the extent to the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that this practice reserves the right to change their notice and practices and prior to implementations, in accordance with Section 164.520 of the Code of Federal Regulations. Should this practice change their notice, they will send a copy of any revised notice to the address I`ve provided (whether U.S. mail or, if I agree, e-mail).

I wish to have the following restrictions to the use and/ or disclosure of my health information:

_____

_____

_____

I fully understand and accept the terms of this consent.

_____ _____

Name over Signature of Patient/Legal Representative **Date**

_____

Relationship to Patient ***(if signed by legal representative)***