



Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my health care, the practice originates and maintains paper and/or 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 serves as:

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

I have been provided the opportunity to review the "Notice of Patient Privacy Information Practices" that provides a more complete description of information uses and disclosures. I understand that I have the following rights:

- The right to review the "Notice" prior to acknowledging this consent,
• The right to restrict or revoke the use or disclosure of my health information for other uses or purposes, and
• 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

Restrictions

I request the following restrictions to the use or disclosure of my health information:

I understand that as part of treatment, payment, or healthcare operations, it may become necessary to disclose health information to another entity, i.e., referrals to other healthcare providers, labs, and/or other individuals or agencies as permitted or required by state or federal law.

I fully understand and accept the information provided by this consent.

Patient Name (print)

Name of person signing (print) Signature* Date

*If other than patient is signing, are you the parent, legal guardian, custodian or have Power of Attorney for this patient, for treatment, payment or healthcare operations. Yes No

FOR OFFICE USE ONLY

Patient refused to sign the consent form.
Patient added Restrictions (see restrictions listed above).
"Consent form" received and reviewed by _ on (date)
"Consent form" placed in the patient's medical record by _ on (date)