Patient Consent Form

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 actualy 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 aboved).

"Consent form" received and reviewed by _ _ on (date)

"Consent form" placed in the patient's medical record by _________________________ on (date)