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

I understand that as part of my healthcare, this 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, i.e. consultations & referrals
- A source of information for applying my diagnosis and treatment information to my bill, for payment purposes
- 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 *"Patient Privacy 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 ***"Patient Privacy Practices"*** prior to acknowledging this consent
- The right to restrict or revoke the use or disclosure of my health information for purposes other than treatment or payment
- 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

AUTHORIZATION TO RELEASE PATIENT INFORMATION PLEASE FILL IN NAMES

Please list any family members or significant others that you give your authorization for this practice to release any of your patient information to. Name, Relationship To You and **Phone Number**: _____

_____

You are responsible for notifying this practice of any changes to this list.

Restrictions:

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

_____

If you do not want us to leave a message on your answering machine or with someone at your home reminding you of an appointment, which may also include non-sensitive healthcare information, please check the box below.

Do not leave a message on my answering machine or with anyone at my home [ ]

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 the information provided by this consent.

_____ _____ _____

Signature Print name of person signing 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.

[ ] Reason for patient refusal to sign_____

[ ] Restrictions were added by the patient (see restrictions listed above)

[ ] " Consent form" received and reviewed by_____ on (date) _____