

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

I understand that as part of my healthcare, this organization originates and maintains health 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 many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I have the right to receive a copy of the *Notice of Information Practices* that provides a more complete description of information uses and disclosures prior to signing this consent. I understand that the organization reserves the right to change their notice and practices, and prior to implementation will post and make available, the revised notice at physical practice site(s). I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested.

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

I also authorize the disclosure of my health information to the following family members or person(s):

I wish to be contacted regarding any test results or treatment plans by the methods indicated:

Please circle: **Home Phone** Yes/No **Cell Phone** Yes/No **Work Phone** Yes/No **Voice Mail** Yes/No
Fax Yes/No **E-Mail** Yes/No **US Mail** Yes/No **None of the above** Yes/No

 Patient Name

 Birth Date

 Signature of Patient or Legal Representative

 Date

 Witness

 Relationship to Patient (if patient is a minor)

OFFICE USE ONLY:

Accepted

Denied

 Signature

 Title

 Date