CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

Patient Name _____ Date of Birth: _____

Person or Practitioner/Provider granted this Consent:

_____

_____

_____

_____

Federal regulations allow me, as your provider, to use or disclose protected health information from your record. Your protected health information may include information both created and received by the practice/facility, may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I may use your protected health information in order to:

- Make decisions about and plan for your care and treatment.
- Refer to, consult with, coordinate among, and manage along with other health care providers for your care and treatment.
- Determine your eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of your health care.
- Perform various office, administrative and business functions that support your practitioner/ provider's efforts to provide you with, arrange and be reimbursed for quality, cost-effective health care.

With this consent form, I am asking you to make this permission explicit. By signing this consent, you are giving me permission to use or disclose your protected health information for these activities. While every precaution is being made to insure confidentiality of information transmitted electronically, please be informed that there exists potential risks to privacy when such information in transmitted.

These uses and disclosures are described more fully in my Notice of Privacy Practices. You have the right to review that Notice before signing this consent. I reserve the right to revise my Notice of Privacy Practices at any time. If I do so, the revised Notice will be posted in the waiting room. You may ask for a printed copy of my Notice at any time.

You may ask me to restrict the use and disclosure of certain information in your record that otherwise would be allowed for treatment, payment, or health care operations. However, I do not have to agree to these restrictions. If I do agree to a restriction, that agreement is binding.

You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation.

This consent is voluntary; you may refuse to sign it. However, I am permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked.

I hereby consent to the use or disclosure of my protected health information as specified above.

_____

Signature of Patient or Personal Representative Date

Relationship of Personal Representative to the Patient: _____