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:

_____

_____

May discuss treatment, payment or healthcare operation with the following persons:

(Please check all that apply) Spouse [ ] Your Children [ ] Relatives [ ] Others [ ] Parents [ ]

Please list the names and relationship, if you checked "Relatives" or "Others" above

_____

_____

Messages or Appointment Reminders: (Please check all that apply)

May we leave a message on your answering machine at home [ ] or at work [ ]. **Do not leave a message [ ]**
May we leave a message with someone at your **home** using the doctor's name or the practice name: Yes [ ] No [ ]
May we leave a message with someone at your **work** using the doctor's name or the practice name: Yes [ ] No [ ]
Messages will be of a non-sensitive nature, such as, appointment reminders.

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.

_____ _____ _____
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 [ ]

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