P#________________
MRN#________________

Patient Consent to the Use and Disclosure of Health Information
For Treatment, Payment, or Healthcare Operations, Per HIPAA Regulations

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, such as referrals,
- 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 rendered
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of staff.

I have been provided with a "*Notice of Patient Privacy Practices*" that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- 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
- 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.

PLEASE PRINT

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

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****Print the name and relationship of whom we are permitted to discuss your protected health information. This includes questions about billing.** (Example: spouse, children, other relatives, friends or caregivers)

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****Messages or Appointment Reminders:**
May we leave a message at your **home** using doctor's/practice name: Yes { } No { }
May we leave a message at your **work** using doctor's/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. I consent to such disclosure for these uses as permitted by law.

I fully understand and **accept / decline (please circle one) the information of this consent.

______________________________________ ________________________

Patient/Guardian Signature Date

____

Print Name of Person Signing

*If other than the patient is signing, are you the legal guardian, custodian or have Power of Attorney for this patient, for treatment, payment or healthcare operations? Yes { } No { }

FOR OFFICE USE ONLY
{ } Consent form received and reviewed by ________________________ on ______________
{ } Consent form signature refused by patient
{ } Patient unable to sign consent form, Reason: ________________________________