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 this information serves as:

- A basis for planning my care and treatment.
- A means of communication among 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 provided.
- A tool for routine healthcare operations, such as assessing quality and reviewing 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 consent
- The right to restrict or revoke use of 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,

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Please tell us with whom we may discuss your/patient's treatment, payment or healthcare operations:

Example: Spouse (name), children (name), other relatives (names), friends or caregivers (names)

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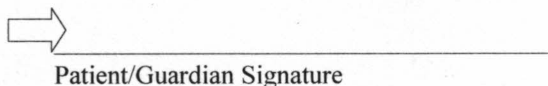
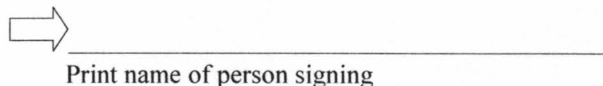
I understand that as part of treatment, payment, or healthcare operations, it may be necessary to disclose health information to another entity, i.e. referrals to other healthcare providers. I consent to such disclosures for these uses as permitted by law.

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



Patient/Guardian Signature



Print name of person signing

If other than 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 [ ] Restrictions added by patient [ ]
"Consent form" placed in patient's medical records on ______________________

Date: ________________________