

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

I understand that as a part of my healthcare, this practice originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and 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, i.e., consultations and referrals
- A source of information for applying my diagnosis and treatment information to my bill for payment purposes
- A survey for routine healthcare operations, such as assessing quality and reviewing the competence of staff

I have been provided the opportunity to review the “Patient Privacy 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 “Patient Privacy Practices” prior to acknowledging this consent
- The right to restrict or revoke the use or disclosure of my health information for purposes other than treatment or payment
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations

Restrictions:

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

If there is anyone you want us to discuss your healthcare information with, please list their names and relationship below:

Messages or Appointment Reminders:

If you do not want us to leave a message on your answering machine or with someone at your home reminding you of an appointment, which may also include non-sensitive healthcare information, please check the box below:

Do not leave a message on my answering machine or with anyone at my home []

I understand that as a part of my 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 the information provided by this consent.

Signature	Printed name of person signing	Date
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*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 []

FOR OFFICE USE ONLY

- [] Patient refused to sign the consent form.
- [] Reason for patient refusal to sign
- [] Restrictions were added by the patient (see restrictions listed above)
- [] “Consent form” received and reviewed by _____ on (date)