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 my 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:
Please list anyone that we cannot discuss your health information with:

_____

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)_____