

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care. I understand that diagnosis or treatment of may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request restrictions as to how my health information is used or disclosed to carry out treatment, payment or healthcare operations of this practice. The above organization is not required to agree to the restrictions I may request. However, if the above organization agrees to a restriction that I request, the restriction is binding on the above organization.

I have the right to revoke this consent, in writing, at any time, except to the extent that the above organization has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information collected from me and created or received by my physician, another healthcare provider, my employer or a health care clearinghouse. This protected information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information will identify me.

I understand that I have a right to review the above organization's right to privacy prior to signing this document. The Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of the above organizations. The Notice of Privacy Practices are also provide at the above organization and on the website if applicable. The Notice of Privacy Practices also describes my rights and the above organizations duties with respect to my protected health information.

The above named organization reserves the right to change the privacy practices that are described in The Notice of Privacy Practices. I may obtain a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Date

Description of personal Representative's Authority