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CONSENT AGREEMENT

Consent to the use and disclosure of Protected Health Information for treatment, payment or other healthcare operations.

I, ____ (patient or representative name), understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examinations and test results, diagnosis, 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 many health professionals who contribute to my care
A source of information for applying my diagnosis and surgical 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 healthcare professionals

I understand that the practice reserves the right to change their notice and practices and prior to Implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, excerpt to the extent that the organization had already taken action in reliance thereon.

I wish to have the following restrictions to the use or disclosure of my Protected Health Information:

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I fully understand and accept/decline the terms of this consent.

Signature: ____ Date: _________________________

Patient's representative: _________________________________

Patient's Name: ____ Date of Birth: _______________________

2/2013