

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

I understand that as part of my health care, this clinic originates and maintains health records describing my health history, symptoms, examination 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 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 health care professionals

I understand and have been provided with a Notice of Information Practices that offers a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the clinic reserves the right to change their notice and practices and prior to implementation will post a copy of any revised notice at the clinic. 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 clinic is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the clinic has already taken action in reliance thereon.

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

_____ None _____

Signature of Patient or Legal Representative

Relationship to Patient

Date

4-11-03

Notice Effective Date

OFFICE USE ONLY

Restrictions: ____Accepted ____Denied

Signature

Title

Date