**HIPAA Compliance 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, examinations 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 retrict 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 may be used or disclosed to carry out treatment, payment or health care operations.

**Restrictions:**
I request the following restrictions to the use or disclosure of my health information:
_____
_____
—

May discuss treatment, payment or healthcare operations with the following persons:
(Please check all that apply) Spouse( ) Children( ) Parents( ) Others( )

Please list the names and relationship if you checked "Others" above
_____
_____

**Messages or Appointment reminders:**
May we leave a message on your answering machine at home disclosing Dr.'s name, appointment time and date? Yes ( ) No ( )

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

_____
Date

**If other than patient signing, are you the parent or legal guardian, custodian or have the Power of Attorney for this patient, for treatment, payment or healthcare operations.
Yes ( ) No ( )