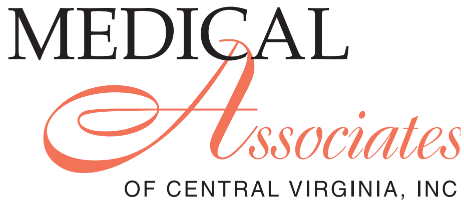

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Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, ____________________________, understand that as part of my healthcare, this practice originates and maintains health 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 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, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I authorize the release of any medical information to my insurance carrier which is necessary to process my insurance claims. I also authorize my insurance benefits to be paid directly to my physician, realizing I am responsible to pay for non-covered services.

I understand and have been provided with a *Notice of Information Practices* that provides 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 organization reserves the right to change its 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 object to the use of my health information for directory purposes. 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, except to the extent that the organization has already taken action in reliance thereon.

I wish to have the following restrictions to the use or disclosure of my health information:

____

____

____

Please indicate up to three people you will allow to contact our office on your behalf for the following circumstances:
I authorize the release of my laboratory results/results of tests to:

(1)________________________________ Relationship:______________________

(2)________________________________ Relationship:______________________

(3)________________________________ Relationship:______________________

I authorize:

(1)____

(2)____

(3)____

to call Medical Associates on my behalf to schedule appointments, change appointments and receive reminders of upcoming appointments.

I authorize:

(1)____

(2)____

(3)____

to call the office to verify if I am ready to be picked up from my visit and/or to pick up prescriptions.

I authorize:

(1)____

(2)____

(3)____

to speak to the Finance Department of Medical Associates in regard to my account/billing.

Any other specific requests for disclosures:
I authorize:

(1)______________________________to______________________________

on my behalf.

I authorize Medical Associates to send reminder notices of upcoming appointments to me via the United States mail.

__________ YES __________ NO

I agree that messages may be left on my answering machine. __________ YES __________ NO

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

______________________________ Signature

______________ Date of Birth

______________ Date

FOR OFFICE USE ONLY:
A copy of *Notice of Privacy Policies* has been issued to the patient on______________.