

**Consent to the Use & Disclosure of Health Information for Treatment,
Payment of Healthcare Operations**

I _____ understand that as part of my healthcare, this practice originates & maintains health records for the last 5 years, after which they may be destroyed, describing my health history, symptoms, examinations, test results, diagnoses, treatment & any plans for future care of treatment. I understand that this information serves as:

1. The basis for my care & treatment.
2. A form of communication between this practice & other healthcare professionals concerning my care.
3. Provides information for applying diagnosis information to my bill & insurance companies.
4. Provides proof of services rendered for third party payors.
5. Provides a tool for healthcare operations in assessing the quality & competence of healthcare professionals.

PLEASE INITIAL EACH OF THE FOLLOWING:

_____ I understand & have been provided/reviewed a Notice of Information & Practices (HIPAA) which gives further clarification of record usage.

_____ I understand that I have the right to review the notice prior to signing this consent.

_____ I understand that this practice reserves the right to change their practices and prior to implementation will provide a copy of any revisions to me.

_____ I understand that I have the right to request restrictions as to how my health information may be used in order to carry out treatment and/or payment. This practice is not required to agree to restrictions requested.

_____ I understand that I may revoke this consent in writing, except where this information has already been used.

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

Signature: _____

Date: _____