HIPAA CONSENT AGREEMENT

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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 organization originates and maintains health records describing my health history, symptoms, examination test results, diagnoses, treatment and any plans for future care or treatment. Understand that this information serve as:

- A basis for planning my care and treatment
- A mean of communications among the many health professionals who contribute to my care
- A source or information for applying my diagnosis and surgical information for 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 understand and have been provided with a *Notice of information Practice*s that provides a more complete description of information uses and disclosures. I understand that I have the right to review notice prior to signing this condensed form. I understand that the organization reserves the right to change their notice and practices and prior to implantation will mail a copy of any revised notice to the address I provided. I understand that I have the right to object to the use of 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 will not require agreeing to the restrictions requested. I understand that I may revise this consent in writing, except to the extent that the organization has already transaction in reliance thereon.

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

Signature of Patient or Legal Representative Witness below

_____ Accepted ____ Denied ____ Date: ___/___/___

_____

Please Print Name Here