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 maintain 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 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've provided. 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:

_____

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

_____ Date: _____

(Patient/Guardian Signature)

- o **DO NOT** release any private/protected health information to anyone other than myself, unless requested by me in writing.
- o **I do hereby request that any of my outstanding test results may be given over the phone or in person to the following individual** (Name: _____ Relationship to patient: _____

This is the only person, other than myself; I authorize information to be given to. By signing below I agree to the following:

I am aware that medical information is considered to be confidential and that when employees or others associated with Life Care Family Practice are discussing my care over the phone, there is not a way of being able to positively verify that they are talking with the above designated person. Therefore, I hold harmless and blameless any person who gives such information over the phone as long as the information given is to the person who states that they are the designated individual listed above.

I understand that this is an attempt to prevent having to make an office appointment for the sole purpose of obtaining labs or other test results. I also understand that there are some results that will not be given to me or anyone else over the phone and an appointment will need to be made to obtain those test results.

Signature: _____ Relationship: _____ Date: _____