Name: _____
DOB: _____

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

I, * _____
Name

, understand that as part of my health care, Edinger Medical Group originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, 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 will be provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent, 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.

I understand that Edinger Medical Group 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 also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

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

I wish to share my electronic medical records in efforts to assist me with current or future care needs:
I understand that I have the right to revoke this privilege in writing.

Name **Relationship**
Email Address **Phone Number**

Patient Consent and Authorization *

- ○ I fully understand and ACCEPT the terms of this consent.
- ○ I fully understand and DECLINE the terms of this consent.

Signature *

Signer's Name *

Today's Date *