

# **CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- **Conduct, plan and direct my treatment and follow- up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.**
- **Obtain payment from third-party payers.**
- **Conduct normal healthcare operations such as quality assessments and practitioner certifications**

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how many private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have take action relying on this consent.

**Patient Name:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

**Relationship to patient:** \_\_\_\_\_

**Date:** \_\_\_\_\_