



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

I, _____, understand that as part of my health care, this office creates and maintains medical records describing my health history, examination and test results, diagnoses, treatment and other related information.

I have received a copy of this office's Notice of Health Information Practices, which outlines how patient confidential information will be used, disclosed, and protected.

Patient Signature (or Authorized Representative)

Date

Name/Relationship if signed by
Authorized Representative

Date



FOR OFFICE USE ONLY

Written acknowledgment not obtained because:

- Individual Declined to Sign
- Communication Barrier
- Care Given Emergently
- Other (describe) _____