Privacy Notice Summary

Consent to the Use and Disclosure of Health Information according to our Notice of Privacy Practices.

I understand that as a 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. I understand that this information services 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 Privacy Practices* that provides a more complete description of information uses and disclosures, and that this form is merely a summary of the *Notice of Privacy Practices*. I understand that by signing this form, I am consenting to the *Notice of Privacy Practices* provided as well as this summary. I have reviewed these documents prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for a particular purpose. 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 agree** to the above *Privacy Practices* and do not request any additional restrictions to the use or disclosure of my health information.

-OR-

____ I request the following **additional** restrictions to the use or disclosure of my health information. Please list your additional restrictions below.

_____

Patient Name

_____ _____

Patient or Guardian if under 18 years old signature Date