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**CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS**

I understand that as part of my Healthcare, this organization originates and maintains health records describing my health history, symptom, examination, test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning 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
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of health care professionals

I understand and have been provided with a Notice of Informational Practice that provides a more complete description of information uses and disclosure. I understand that I have the right to review the notice prior to signing this consent. 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 I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

_____
Patient's Name

_____ Date:____/____/_____
Signature of Patient or Legal Representative