Consent for Purposes of Treatment, Payment And Healthcare Operations

My “protected health information” means health information, including my demographic information collected from me and created or received by my physician. This protected health information relates to my past, present or future physical or mental health condition and identifies me or there is a reasonable basis to believe the information may identify me.

I consent to the use or disclosure of my protected health information by Dr. Angela H. Baylis for the purpose of diagnosing or providing me treatment to me, obtaining payment for my health care bills or to conduct health care operations of Dr. Angela H. Baylis. I understand that Dr. Baylis, may refuse to diagnose or treat me, if I do not consent to the disclosure of my protected health information for the purposes stated above. (My signature on this document is evidence of this consent).

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of practice. Dr. Angela H. Baylis, D.C. is not required to agree to the restrictions that I may request. However, if Dr.Angela H. Baylis agrees to a restriction that I request, the restriction is binding on Dr. Baylis.

I understand I have a right to review Dr.Angela H. Baylis D.C. Notice of Privacy Practices prior to signing this document. Dr.Baylis’s Notice of Privacy Practices has been provided to me. The notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Dr.Baylis. The Notice of Privacy Practices for Dr. Baylis is also provided on request at the main administrative desk of this practice. Notice of Privacy Practices also describes my rights and Dr. Baylis’s duties with respect to my protected health information.

Dr. Angela H. Baylis reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling Dr. Baylis’s office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I have the right to revoke this consent, in writing at any time, except to the extent that Dr. Baylis has taken action in reliance on this consent.

____ ____________________

Signature of Patient or Personal Representative Date

____

Name of Patient or Personal Representative

____

Description of Personal Representative’s Authority