Consent for Purposes of Treatment, Payment and Health Care Operations

Patient Name _____

1. I consent to the use or disclosure of my protected health information by Quality Care Family Practice for the purpose of diagnosing, providing treatment, obtaining payment for my health care bills, and to conduct health care operations of Quality Care Family Practice.

2. I understand that diagnosis and treatment by Quality Care Family Practice may be conditioned upon my consent as evidenced by my signature on this document.

3. I understand I have the right to request a restriction as to how my health information is used or disclosed to carry out treatment, payment, and health care operations of the practice.

4. Quality Care Family Practice is not required to agree to the restrictions that I may request. However, if Quality Care Family Practice agrees to a restriction that I request, the restriction is binding on Quality Care Family Practice.

5. I have the right to revoke this consent in writing at any time; except to the extent Quality Care Family Practice has taken action in reliance to this consent.

6. My "protected health information" means both health information, including my demographic information collected from me or received by my physician, another health care provider, a health plan, my employer, and a health care clearing house. This protected information relates to the past, present, and future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

7. I have received a copy of Notice of Privacy Practices, and I have had the opportunity to review Quality Care Family Practice policy for use and disclosure of personal health information for treatment, payment of my bills and in the performance of health care operations of Quality Care Family Practice.

8. The Notice of Privacy Practices also describes my rights and duties to Quality Care Family Practice with respect to my protected health information.

9. Quality Care Family Practice reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

10. I may obtain a revised Notice of Privacy Practices by asking for one at the time of my next appointment, or by calling the office and requesting that one be sent to me in the mail.

_____ _____

Date **Description of Authority (Mother, Father, etc.)**

_____ _____

Printed Name of Patient or Guardian **Signature of Patient or Guardian**