Carroll Family Medicine
New Patient Consent to the Use and Disclosure of Health Information
For Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Carroll Family Medicine, LLC originates and maintains paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnoses, treatments, and any plans for future care or treatment. I understand that this information serves 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 Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations and the right to restrict certain disclosures of PHI (protected health information) to a health plan when the individual pays out of pocket in full for the health care item or service.

I understand that Carroll Family Medicine, LLC participates with CRISP *(Chesapeake Regional Information System for our Patients).* If I choose to opt out of the use of this program, I need to see the Receptionist and file the proper form.

I understand that Carroll Family Medicine, LLC 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 take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section *164.506* of the Code of Federal Regulations.

I further understand that Carroll Family Medicine, LLC reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Carroll Family Medicine, LLC change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____
_____
_____

I understand that as part of my treatment, Carroll Family Medicine, LLC may determine that I should visit a specialist or other physician. I understand that certain information may be used or disclosed to the referring healthcare provider. I specifically authorize any current employee or owner of Carroll Family Medicine, LLC to release or disclose my protected health information to the specialist or other medical practice. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

Description of the information that may be used or disclosed:

- The patient's demographic information (i.e. name, address, age, gender, telephone number)
- Medical Data/Information as related to the specified condition discussed with patient by Physician (i.e. condition, professional service needed, medications, etc)

The patient has a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for revocation of this authorization to be effective, Carroll Family Medicine, LLC must receive the revocation in writing.

The revocation must include:
- The patient's name, address, and phone number, if applicable.
- The effective date of this authorization, and the recipients of the PHI according to this authorization.
- The patient's desire to revoke this authorization.
- The date of the revocation, and the patient's signature.

Carroll Family Medicine, L.L.C. will accept written revocations of this authorization via:
- Certified U.S. Mail
- Facsimile at this number: 410-239-0407

Acknowledgment of Receipt of Privacy Notice

I have been presented with a copy of Carroll Family Medicine, LLC's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

Further, I permit a copy of this authorization to be used in place of the original. I hereby authorized the physician to furnish information to insurance carriers concerning this illness/accident, and I hereby irrevocably assign to the doctor all payments for medical services rendered. Regulations pertaining to medical assignment of benefits apply. I understand that I am financially responsible for all charges whether or not covered by insurance.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

The following persons have permission to receive my protected health information (i.e. spouse, parents, etc).

_____

_____

_____

I understand I have the right to revoke the above permission in writing at any time. I fully understand and Accept/Decline (circle one) the terms of this consent.

_____
Patient's Signature

_____
Date

_____
_____