MIDWEST REGIONAL HEALTH SERVICES, LLC.

HIPAA CONSENT

Expiration Date

Consent to Use and Disclose Protected Health Information for Treatment, Payment, and Healthcare Operations

I understand that as part of my health care, Midwest Regional Health Services, LLC originates and maintains electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, 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 Authorize Midwest Regional Health Services to disclose personal health information to the following people.

Name of Individual	Relationship	Name of Individual	Relationship

I understand that I may request a ***Notice of Health 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, 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

I understand that Midwest Regional Health Services, 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 taken action in reliance theron. I 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 Midwest Regional Health Services 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 Midwest Regional Health Services 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, e-mail)

I wish to have the following **restrictions** to the use or disclosure of my protected health information other than those listed in Midwest Regional Health Services Privacy Policy:

Restrictions: ____

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.

CONSENT TO LEAVE PHONE MESSAGES

ONLY INITIAL ***if you Authorize Midwest Regional Health Services to leave detailed messages regarding your care or lab results.***

____________ Voicemail on preferred phone number (Home Work Cell) Please circle

Patient Initials

I fully understand and accept the terms of these Privacy Consents

Signature of Patient or Legal Guardian	Relationship to patient	Today's Date

Patients Name (written)	Date of Birth