PAUL M. PUZISS, M.D., P.C.

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ORTHOPEDIC SURGERY SHOULDER CLINIC OF PORTLAND
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Diplomate American
Board of Orthopedic
Surgery

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations:

I, _____, understand that as part of my healthcare, Dr. Puziss originates and maintains paper and/or electronic records describing my health history, symptoms, examination, 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
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals
- A resource for attorneys to collect and compile information regarding your legal representation
- An authorization to obtain motor vehicle policy information, including P.I.P. limits and available funds.

I understand and have been provided with 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
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed in order to carry out treatment, payment, or healthcare operations.

I understand that Dr. Puziss 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 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 Dr. Puziss reserves the right to change his *Notice of Privacy Practices* prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Dr. Puziss' office change its notice, it will send a copy of any revised notice to the address I have provided (by U.S. mail or, if I agree, e-mail).

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

_____
_____
_____
_____

I understand that as part of this organization's treatment, payment, or healthcare 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.

I fully understand and accept/decline the terms of this consent.

_____ _____
Patient's Signature Date

Rev. 02/2013

FOR OFFICE USE ONLY
[ ] Consent received by _____ on _____
[ ] Consent refused by patient, and treatment refused as permitted
[ ] Consent added to the patient's medical record on _____