Consent to the Use and Disclosure of Health information for Treatment, Payment or Healthcare Operations

I, ______________________________________, understand that part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses treatment and 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 health care professionals

I understand and have been provided with a *Notice of Privacy Practice* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change its notice and practices and prior to implementation, will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have 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 organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing. I have been provided with a complete copy of the Notice of Privacy Practice to review; and I acknowledge through my signature receipt of the Notice of Privacy Practice. Cedar Plains Family Medicine Notice of Privacy Practice is available upon request.

I fully understand and accept the terms of this consent.

Signature ____ **Date** _____________________________