Hazelwood Family Medicine, PLLC

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

I, _____, understand that as part of my healthcare, Hazelwood Family Medicine originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis 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, in order to bill me or my insurance,
* 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 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 the 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 healthcare operations.

I understand that Hazelwood Family Medicine 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 Hazelwood Family Medicine reserves the right to change their practices and to make the new provisions effective for all protected health information they maintain, in accordance with Section 164.520 of the Code of Federal Regulations. Should Hazelwood Family Medicine change their notice, the revised notice will be posted in their reception area and will be made available upon request.

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

_____

_____

_____

I give permission to Hazelwood Family Medicine, PLLC for the following:

- ☐ **to leave messages on my answering machine concerning appointments, other aspects of my medical care, and account issues.**
- ☐ **to leave messages with whoever answers the phone at my house.**
- ☐ **to discuss any aspect of my medical care with** _____.

Please consider the answers to the above questions carefully. Your election will remain in force until changes are received by our office in writing.

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 purposes, including disclosures via fax or electronic health record.

I fully understand and accept decline (check one) the terms of this consent.

_____

Patient's Signature Date