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CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS & ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

NAME _____BIRTH DATE _____ SOCIAL SECURITY # _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare 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 care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

❑ I request the following restrictions to the use or disclosure of my health information:

_____

I authorize doctor and staff to disclose my Private Health Information and medical status to the following person (s). **Emergency contacts are designated by check mark ☑**

_____	_____	(_____)_____	
☐ Name	Relationship	Area code	phone #
_____	_____	(_____)_____	
☐ Name	Relationship	Area code	phone #
_____	_____	(_____)_____	
☐ Name	Relationship	Area code	phone #

ACKNOWLEDGEMENT
Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish. By signing I acknowledge that I have received a copy of this office's Notice of Privacy Practices. ***[Published on Patient Portal https://health.eclinicalworks.com/drcanasi]***

Patient:

_____	_____	_____	_____
Signature of Patient or Legal Representative	Relationship to Patient	Date	Witness Signature

FOR OFFICE USE ONLY: We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

❑ Refused to Sign ❑ Due to an emergency situation it was not possible to obtain an acknowledgement

❑ Unable to communicate with patient ❑ Other: _____

_____	_____
Employee Signature	Date