CONSENT TO RELEASE OF

PROTECTED HEALTH INFORMATION

FOR TREATMENT, PAYMENT

OR HEALTHCARE OPERATIONS

I understand that my healthcare provider creates and uses a record of my health history and related financial information that may be used for:

Continuing care and treatment

Communicating with other healthcare professionals who are involved in my care

Deriving information used in billing for my care

A means of responding to insurers requests for information about my care, and/or

Review in quality assessment projects designed to help the clinic improve its ability to provide good healthcare.

My signature below authorizes the above uses of my records and also signifies that I was given a "Privacy Notice" and that this notice provides a more complete description of the ways my medical records might be used or disclosed when I registered as a patient of this clinic. I understand that the clinic policies about using information might change from time to time and that I can obtain another copy of the notice at the front desk any time I want one.

I know that I can request restrictions on the way my healthcare information is used, but I also understand that the clinic is not required to abide by my restrictions. I also understand that I can revoke this consent at any time, but that this revocation will not apply to uses of my records between the date of this consent and the date of revocation.

Please restrict the use of my records as follows:

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Signed:_____

Date:_____