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CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I understand that as a part of my treatment, this facility originates and maintains health records describing my health history, symptoms, examinations and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- Basis for planning my care and treatment
- A means of communication among any other health care professionals who might contribute to my care, for example via facsimile, telephone, etc.
- A source of information for applying my diagnosis and surgical information to my account to process for payment
- A means by which a third-party payer can verify that services billed are accurate and actual.
- And as a tool for routine healthcare operations, such as assessing quality and reviewing the competence of healthcare officials.
- A means of communication among my health care professional who might contribute to my care via Telemedicine, Patient Portal, phone calls and virtual check in (phone/text)

I understand this practice will take great care to insure that any and all information pertaining to me, and my treatment here, will be handled with an emphasis on maintaining my privacy at all times. 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 healthcare operations, and that this facility is not required to agree to these restrictions, in the event of an emergency. I understand that I may revoke the consent in writing, at any time.

Print Name of Patient, or Legal Guardian

I have read, understand, and accept the terms of this consent to the above use of my Personal Health Information (PHI).

Signature of Patient or Legal Guardian