ENDOCRINOLOGY ASSOCIATES OF MONTGOMERY, P.A.

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Patient Consent to the Use and Disclosure of Medical Records for Treatment, Payment or Healthcare Options

I, _____, understand that as part of my healthcare, Endocrinology Associates of Montgomery, P.A. (EAM) originates and maintains paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future health care treatment. I understand that this information serves as:

A basis for planning my care and treatment;

A source of information for applying my diagnosis and surgical information to pay bill;

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 assesing quality and reviewing this competence of healthcare professionals.

I understand and have been provided with a *Notice of Privacy Policies* that provide 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 this consent;

The right to reject 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 options.

In addition to myself, I consent to the following adult individuals to have access to my medical records: (Please give full name and address)

_____

_____

_____

I understand that EAM is not required to agree to the restrictions requestied. 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 EAM reserves the right to change their notice and practices in accordances with Section 164.520 of the Code of Federal Regulations.

I understand that as part of this organizations treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another party, and I consent to such disclosure for these permitted uses, including discosures via fax.

_____

Patient's Signature

_____

Date

FOR OFFICE USE ONLY

[ ] Consent received by _____ on _____

[ ] Consent refused by patient, and treatment received as permitted.

[ ] Consent added to this patient's medical records on _____