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

I, ____, understand that as part of my healthcare, this practice 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 health 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 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 information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation, mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restriction 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. 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 wish to have the following restriction to the use or disclosure of my health information.

____

How would you like to be contacted regarding appointments, treatment and / or other information pertinent to your healthcare and / pr payment for our healthcare provided at COMPLETE CARE REHAB, LLC? (Check all that apply)

Home Phone # ______________ Cell Phone # ___________________ E-mail:________________________

__________________ I fully understand and accept the terms of this consent.

__________________ I fully understand and decline the terms of this consent.

Patient Signature:
(OR Legal Guardian /Responsible Party) ___________________________________ **Date:** __________________