Patient Consent to Use and Disclosure of Health Information
For Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my healthcare, PRIME MEDICAL ASSOCIATES LLC's office originates and maintains papers and /or electronic records describing my health history, symptoms and examination and test result, diagnoses, treatment, and any plans for future care or 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 testify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of the healthcare professionals.

I understand and have been provided with *Notice of Information Practices* that provides 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 object to the use of my health information for directory purposes, and
- The right to request restriction as to how my health information my be used or disclosed to carry out treatment, payment or healthcare operation

I understand that PRIME MEDICAL ASSOCIATES LLC's office is not required to agree to the restriction requested. I understand that I am revoking this consent in writing, except to the extent that the organization has already take 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 the PRIME MEDICAL ASSOCIATES LLC's office reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should PRIME MEDICAL ASSOCIATES LLC's office change their notice, they will send a copy of any revised notice to the address I have provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.
I fully understand and accept/decline the terms of this consent

_____ _____
Patient's Signature Date

Who else do you give authorization to receive your medical information?
Name _____ D.O.B: _____
Relationship: _____
Address:_____
Tel: _____

FOR OFFICE USE ONLY
[ ] Consent received by _____ o n _____ .
[ ] Consent refused by patient, and treatment refused as permitted.
[ ] Consent added to the patient's medical record on _____.