Consent for Use and Disclosure of Protected Health Information For Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, the Physician originates and maintains medical records describing my health history, symptoms, examinations and test results, diagnosis, treatment, financial and demographic information, and any plans for future care or treatment. The Physician also originates and maintains bills records. I understand and consent to this information being used or disclosed for the following purposes:

- Planning my care and treatment;
- Communication between my Physician and healthcare professional that act under the direction of my Physician and participating in my diagnosis, evaluation, or treatment;
- Collection of fees for medical services;
- Determining liability for payment and obtaining reimbursement;
- Conducting healthcare operations, including the evaluation of healthcare services, appropriateness and quality of healthcare treatment, and the qualifications of healthcare practitioners.

I have been provided with a copy of the *Physician's Notice of Privacy Practices* that provides information about how the Physician uses and discloses Protected Health Information (PHI) about me. I understand that I have the following rights and privileges:

- The right to review the notice prior is signing this consent, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations. The Physician is not required to agree to the requested restrictions, but is bound to any restrictions agreed to.

I understand that as provided in the *Physician's Notice of Privacy Practices*, the terms of the Notice may change. If they do, I may obtain a revised copy from the Privacy Officer by calling 432-618-6772 ext. 108.

I understand that I may revoke this consent in writing, except to the extent that the Physician has already acted in reliance thereon. I also understand that by refusing to sign or by revoking this consent, the Physician may refuse to treat me. I wish to restrict the use or disclosure of my health information as follows:

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I understand that my confidential information may be released to the following individuals:

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Patient's Name (please print)	**Date of Birth**
Patient Signature	**Date**
Representative Name (if applicable)	**Relationship**