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

I, ____ understand as part of my health care we, **Bay Center for Jaw Surgery** originates and maintains paper and/or electronic records describing my health history, symptoms, examinations and test results, 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 health professionals who contribute to my care, such as referrals,
- A source of information for applying my diagnosis and treatment information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided,
- A tool for routine health operations, such as assessing quality and reviewing the competence of staff.

I have been provided with a *Notice of Patient Privacy 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 view the *Notice* prior to signing this consent,
- The right to restrict or revoke the use or disclosure of my health information for other uses or purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I further understand that **Bay Center for Jaw Surgery** reserves the right to change their notice and practices, in accordance with Section 164.520 of the Code of Federal Regulations. Should **Bay Center for Jaw Surgery** change their notice, I may request a copy of any revised notice in person (or by U.S. mail, to be sent to the address I've provided).

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

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Please tell us with whom we may discuss your/patient's treatment, payment or healthcare operation:
Example: spouse (name), children (names), other relatives (names), friends or caregivers (names)

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Appointment Reminders:
May we leave an appointment reminder message at your home using doctor's / practice name? ❒ Yes ❒ No
May we leave an appointment reminder message at your work using doctor's / practice name? ❒ Yes ❒ No
Do not leave message ❒

I understand that as part of treatment, payment, or healthcare operation, it may become necessary to disclose health information to another entity, i.e., referrals to other healthcare providers. I consent to such disclosure for these uses as permitted by law.

I fully understand and accept / decline the terms of this consent.

*If other than patient is signing, are you the legal guardian, custodian or have Power of Attorney for this patient, for treatment, payment or healthcare operations? ❒ Yes ❒ No

_________________________________ _________________________________
Patient / Guardian Signature Printed name of person signing

____
Date

FOR OFFICE USE ONLY
❒ Consent received by _________________________________ on ____________________
❒ Consent refused by patient ❒ Restrictions
❒ Consent added to the patient's record on ____________________