

**PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

Patient name: _____ Date of birth: _____

SSN (optional): _____ Previous name: _____

Your health information is a private matter. The office of Harrison HealthPartners has a form that can tell how the office of Harrison HealthPartners handles your health information. This form is called "Notice of Privacy Practices". If you ask, the receptionist will be happy to provide you with the most current "Notice" before you sign this consent. There are also "Notices" in our waiting area for your review. The office of Harrison HealthPartners may update this "Notice" at any time. If you ask, you will get a copy of the most current "Notice".

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting reception services for our practice and asking for the Privacy Officer. Unless you object, in writing, our office will contact you regarding appointments, lab and x-ray results. If we are unable to reach you we may, unless you object, leave a message with a family member, friend or answering machine.

I agree that the office of Harrison HealthPartners may use and disclose my health information to help treat me. I agree that the office of Harrison HealthPartners may use and disclose my information for billing and payment. I also agree to use and disclosures of my health information to take care of other health care operations. In general, no other use or disclosures of my health information will occur unless I tell the office of Harrison HealthPartners it's okay.

You may cancel this consent at any time, by doing one of the following:

- * Signing and dating a revocation form. You may get this form from our receptionist; or
- * Writing, signing, and dating a letter to the office of Harrison HealthPartners The letter must say you cancel your consent to authorize the use and disclosure of your health information for treatment, payment, and health care operations.

If you cancel this consent:

- * It will be effective except for actions already taken based upon the consent.
- * The office of Harrison HealthPartners will not have to provide any more health care services to you.

I have been given the chance to read a current copy of the office of Harrison HealthPartners "Notice of Privacy Practices". I agree to allow the office of Harrison HealthPartners to use and disclose my health information to carry out treatment, payment, and health care operations.

Patient or legally authorized individual signature

Date

Relationship to patient if signed on behalf of the patient by parent, legal guardian, personal representative, etc.