Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations 9.2013

I understand that as part of my healthcare, the offices of Dr. Stephen Trammell originates and maintains health records describing my health history, symptoms, examination 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 many health professionals who contribute to my care
- 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, and
- A tool for routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals

I understand that the offices of Dr. Stephen Trammell, its agents, employees and contractors may use and disclose my health care information for these and other treatment, payment and health care operations.

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 following rights and privileges:

- The right to restrict information that was paid in full by myself and not by an insurance company
- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for data or directory purposes, 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, and

I understand that Dr. Stephen Trammell reserves the right to change its notices and practices and is not required to agree to the restrictions requested. The offices of Dr. Stephen Trammell will provide each patient with a copy of the revision of its notice and practices at the time of the patient's next visit. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action on it.

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

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I fully understand and accept / decline (CIRCLE ONE) the terms of this consent.

Signature of Patient or Legal Guardian/Representative ________________________________

Print Name: ______________________________ **Date:** ________________________

Relationship to Patient:____

Print Patient Name: ____________________________ **Date of Birth:** ______________