I, _____, understand that as part of my health care, the Practice listed above originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, as well as plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment;
- A means to facilitate communication among the many healthcare 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 verify that services billed were actually provided; and
- A tool for healthcare operations of the Practice such as assessing quality of care and reviewing the competence of healthcare professionals

I understand that as part of the Practice's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity for the purposes stated above.

I understand and have been provided with a ***Notice of Privacy Practices*** that provides a more complete description of how the Practice may use and disclosure my protected healthcare information. I further understand that the Practice reserves the right to change its ***Notice of Privacy Practices.*** Should the Practice change its ***Notice of Privacy Practices***, an amended copy will be posted in a prominent location in the practice site, or, upon my request, an amended copy will be sent to the address I have provided.

I agree that the Practice may do the following unless I specifically give direction prohibiting such activity:

- Send visit reminders and test results to the address I have provided.
- Send routine correspondence, such as billing statements, to the address I have provided.
- Leave messages on an answering machine or voice mail associated with the telephone numbers I have provided to either confirm appointments or to request that I call the Practice on medical or billing matters.
- I agree that the Practice may share billing information with my spouse and/or the person holding the insurance to secure payment. Other persons with whom the Practice may discuss billing information include _____.
- I give the Practice permission to share medical information with the following relatives or friends involved in my care: _____.

_____

Patient's Signature or Signature of Personal Representative

_____

Date

FOR OFFICE USE ONLY

[ ] Receipt received by _____ on _____.

[ ] Patient refused to sign receipt. _____ (Signature of Practice Representative)