MULTICARE PHYSICIANS

Consent to Use or Disclose Information for Treatment, Payment or Healthcare Operations

_____ _____

Print Name of Patient Patient Date of Birth

The patient hereby consents to the use or disclosure of his/her protected health information and patient medical record information by Multicare Physicians (the practice) In order to carry out treatment, payment, or healthcare operations as described in the Practice's Notice of Privacy Practices. The patient has the right to review The Notice Of Privacy Practices before signing this consent form.

The patient reserves the right to change the terms of its Notice of Privacy Practices at any time. If the Practice does change the terms of its Notice Of Privacy Practices, the patient may obtain a copy of the revised notice.

Patient retains the right to request that the Practice further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to such requested restrictions; however, if the Practice does agree to the patient's requested restrictions; such restrictions are then binding on the practice.

Patient acknowledges and agrees that the Practice may disclose patient's protected health information to the following individuals who are the patient's family members, legal representatives, guardians, healthcare surrogates, or have power of attorney on behalf of the patient:

_____

_____

UNLESS YOU INDICATE OTHERWISE IN WRITING ON THIS CONSENT FORM, IF YOU ALLOW A THIRD PARTY OTHER THAN ONE OF OUR PRACTICE PHYSICIANS OR STAFF MEMBER TO BE IN THE EXAM ROOM WHILE YOU ARE BEING EXAMINED OR DISCUSSING YOUR CARE, TREATMENT OR MEDICAL CONDITION WITH YOU, BY SIGNING THIS CONSENT FORM YOU ARE CONSENTING TO THE DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION TO THAT THIRD PARTY.

The Patient agrees that the Practice may disclose the following types of information contained in the Patient's medical records ***(please initial the appropriate categories listed below. Check marks are not acceptable)***

_____ HIV/AIDS Information
_____ Mental Health Information
_____ Substance Abuse Information
_____ Sexually Transmitted Disease Information
_____ If Patient is under the age of eighteen (18), Pregnancy information

At all times, patient retains the rights to revoke this consent. Such revocation must be submitted to the practice in writing. The revocation shall be effective except to the extent that the Practice has already taken action in reliance on the consent.

This Practice reserves the right to refuse to treat a patient if he/she or an authorized representative or guardian does not sign this consent for. If the patient or their authorized representative or guardian signs this form and then revokes it, the Practice reserves the right to refuse to provide further treatment to the patient as of the time of the revocation (except to the extent that the practice is required by law to treat individuals)

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I AM THE PATIENT OR I AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS SEALED DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

Date:_____ Time:_____

_____
Signature of Patient or *Authorized Representative

_____
Print Name

Authorized Representative's Relationship To The Patient

*Please explain Representative's relationship to Patient and include a description of the Representative's authority to act on behalf of the patient.

Notice: This document must be notarized if it is not signed in the presence of an authorized Multicare Physicians employee.