

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

I, _____, understand that as part of my health care, Roots WellCare, P.A., originates and maintains paper and/or electronic 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 many health professionals who contribute to my care,
- A source of information for applying my diagnosis to my bill,
- A means by which a third-party payer can verify that services billed were actually provided,
- A means of obtaining payment from your insurance carrier and/or you, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

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 review the notice prior to signing this consent, 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 understand that Roots WellCare, P.A. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Roots WellCare, P.A. reserves the right to change their notice and practices in accordance with Section 164.520 of the Code of Federal Regulations. Should Roots WellCare, P.A. change their notice, they will send a copy of any revised notice to the address I have provided (whether U.S. mail or, if I agree, email).

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

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and **accept / decline** the terms of this consent.
(circle one)

Patient's Signature

Date

If not signed by patient, please indicate relationship to patient (e.g., spouse, parent, guardian)

Relationship: _____

Witnessed by: _____

FOR OFFICE USE ONLY:

- Consent received by _____ on _____, 20____.
- Consent refused by patient, and treatment refused as permitted.
- Consent added to the patient's medical records on _____, 20____.