CONSENT TO USE AND DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

PRINT PATIENT NAME:____

DATE OF BIRTH:___________________ SOC. SEC. #_______________________

I understand that, as part of my healthcare, Southeast Neuroscience Center originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care and treatment.

I understand that this information serves as:

- A basis of planning my care and treatment
- A means of 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
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals

I understand that I have the right:

- To object to the use of my health information for directory purposes
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon

I understand that I have the right to receive a copy of Southeast Neuroscience Center's Notice of Privacy Practices

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I hereby authorize the use and disclosure of ALL of my individually identifiable health information to Southeast Neuroscience Center. I understand that this information is voluntary. I understand that if the organization authorized to receive the information is not a health plan or a healthcare provider the released information may no longer be protected by federal privacy regulations. I understand that I may revoke this authorization by notifying Southeast Neuroscience Center in writing. Should I do so, this action will not have any effect on any actions taken by the providing organization before they received the revocation.

I request that the following people NOT be given access to my records without specific written consent:

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THIS RELEASE WILL EXPIRE ONE (1) YEAR FROM DATE SIGNED.

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Signature of Patient or Patient's Representative Date