Koithan, PC

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

I understand that as part of my care, **Koithan, PC** will originate and maintain paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

A basis for planning my care and treatment, including communication between providers in the practice.
A source of information for applying my diagnosis and procedure 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 health care operations such as quality assurance.

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,
The right to request restrictions as to how my health information may be used or disclosed.

I understand that Koithan, PC 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 in reliance thereon. 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 Koithan, PC reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.5220 of the Code of Federal Regulations. Should Koithan, PC change their notice, they will send a copy of any revised notice to the address I've provided (U.S. Mail or, if I agree, Email).
I wish to have the following restrictions to the use or disclosure of my health information:

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_____

I, _____, understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my or my dependent's protected health information. I consent to the disclosure to my insurance carrier for the purpose of payment. A photocopy of this authorization will be valid as the original.

I fully understand and [ ] accept [ ] decline the terms of this consent (check one).

_____ _____
Signature of Patient or Authorized Patient Representative Date

_____
Relation to Patient

FOR OFFICIAL USE ONLY

[ ] Consent received by_____ On_____
[ ] Consent refused by patient, and treatment refused as permitted.
[ ] Consent added to the patient's medical record on._____