Consent For the Use and Disclosure of Protected Health Information

I hereby consent to the use and disclosure of my protected health information by Creekside Medical Clinic staff and their business associates for purposes of **treatment**, various activities associated with **payment,** and **healthcare operations**. I understand that protected health information is individually identifiable (e.g., name, social security number, date of birth).

I understand that uses and disclosures of my protected health information for treatment, payment, and healthcare operations include, but are not limited to the following:

- Using or disclosing health information in order to make a diagnosis or provide treatment to me
- Submitting health information to health insurance companies in order to obtain payment for treatment or services rendered
- Sharing health information with other healthcare providers with which I have a treatment relationship
- Review my health information during quality assessment activities and training of medical personnel

I understand that I may request a more detailed explanation of Creekside Medical Clinic's privacy practices prior to signing this consent. I also understand that the terms of the *HIPAA Notice of Privacy Practices* may change and that I may request a revised notice by contacting Creekside Medical Clinic.

I understand that I have the right to request that the provider restrict how it uses and discloses my protected health information in order to carry out treatment, payment, or healthcare operations. I understand that the provider is not required to agree to the restrictions, but that if the provider agrees, the restriction is binding.

I understand that I have a right to revoke this consent, but I must do so in writing. I understand that a revocation applies to the provider's use and disclosures made after the revocation is made. I also understand that if I revoke this consent, I may be denied treatment.

Patient Name *(please print)*	Name of Parent or Legal Guardian
Signature of Patient, Parent, or Legal Guardian	Date Signed

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