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, their staff, and their business associates in order to carryout Treatment, Payment, or Health Care Operations. I understand that Protected Health Information means my health information, which is individually identifiable (e.g. name, social security number, date of birth).

I understand that uses and disclosures for Treatment, Payment, or Health Care Operations include, but are not limited to:

- Using or disclosing health information in order to make a diagnosis or provide treatment to me,
- Submit health information to the health insurance company in order to obtain payment for treatment or services rendered,
- Share health information with other health care providers in which I have a treatment relationship, and
- Review my health information during quality assessment activities and training of medical personnel.

I understand that I have a right to receive a more detailed explanation of the Provider'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 the person listed below and that a revised notice will be posted in the patient waiting area of the Provider's office.

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 Health Care 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 that I must do so in writing. I also understand that a revocation applies to the Provider's use and disclosures made after the revocation is made.

Signed: _____ Date: _____

Name (Print): _____

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