

# REHAB PARTNERS, P.C.

## Patient Consent for Use and/or Disclosure of Protected Health Information

Patient Name	
Social Security Number	Date of Birth

- I understand that as part of my health care treatment, (Health Care Provider) develops and maintains records containing my health information, which includes information about my health history, symptoms, test results, diagnoses, treatment, and claims and payment history, *etc.* I understand that my health information will be used and disclosed by (Health Care Provider) for Treatment, Payment and Health Care Operations and serves as:
  - a basis for planning my care and treatment;
  - a means of communicating among health professionals who may contribute to my care;
  - a source of information to bill for health care services rendered;
  - a means by which an insurance company or other third party payor can verify that services billed were actually provided; and
  - a resource for “health care operations”, such as assessing quality of care and reviewing the competence of health care professionals.
- I have been provided with (Health Care Provider)’s Privacy Notice (the “Privacy Notice”), which provides a more complete description of the use and disclosure of my health information. I understand that I have the right to review the Privacy Notice prior to signing this Consent form. I understand that (Health Care Provider) can change the terms of the Privacy Notice and that (Health Care Provider) reserves the right to make the new Privacy Notice provisions effective for my health insurance that it already maintains and uses, as well as for any health information that it may receive in the future.
- I understand that if I refuse to sign this Consent form allowing for the use and disclosure of my health information to carry out treatment, payment or health care operations, (Health Care Provider) may refuse treatment.
- I understand that I have the right to request that (Health Care Provider) restrict how my health information is used or disclosed to carry out treatment, payment or health care operations, but such requests **may not be accepted**. I request the following restrictions (“N/A” if not restrictions). \_\_\_\_\_  
\_\_\_\_\_
- I understand that I may revoke this Consent at any time by notifying (Health Care Provider) in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the revocation.

\_\_\_\_\_  
Signature of (Health Care Provider) Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient’s Representative (if applicable)

\_\_\_\_\_  
Representative’s Relationship to Patient (if applicable)

**PATIENT CONSENT FOR USE AND/OR DISCLOSURE  
OF PROTECTED HEALTH INFORMATION**

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***To Be Completed by (Health Care Provider)***

The requested restrictions on the use and/or disclosure of the patient's health information are:

\_\_\_\_\_ Accepted      \_\_\_\_\_ Denied

\_\_\_\_\_  
Signature of (Health Care Provider) Representative

\_\_\_\_\_  
Date