

Health Information Consent for Purpose of: Treatment, Payment, and Healthcare Operations.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I consent to the use or disclosure of my protected health information by The Bolick Clinic for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of The Bolick Clinic. I understand that Dr. Bolick may refuse to diagnose or treat me, if I do not consent to the use or disclosure of my protected health information for the above stated purposes. (My signature on this document is evidence of this consent).

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. The Bolick Clinic is not required to agree to the restrictions that I may request. However, if The Bolick Clinic agrees to a restriction that I request, the restriction is binding on The Bolick Clinic and Dr. Channing C. Bolick.

I understand I have a right to review The Bolick Clinic’s Notice of Privacy Practices prior to signing this document. The Bolick Clinic’s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the type of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of The Bolick Clinic. The Notice of Privacy Practices for The Bolick Clinic is also provided to me on request at the main administrative desk of the practice. The Bolick Clinic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling The Bolick Clinic and requesting a revised copy or asking for one on my next appointment.

I have the right to revoke this consent, in writing; at any time except to the extent The Bolick Clinic or Dr. Channing C. Bolick has taken action in reliance on this consent.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative’s Authority

*This document is meant to come into compliance with the HIPPA Federal guidelines concerning patient privacy and record keeping.