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

I, ______________________________, understand that as part of my health care, The Oakland Medical Group, P.C. originates maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serve as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical 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 healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I acknowledge that a copy of The Oakland Medical Group, P.C. Notice of Privacy Practices was posted in a clear and prominent place where I was able to read the Notice of Privacy Practices. I know that I could request a copy and take it with me. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that The Oakland Medical Group, P.C. 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 take 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 The Oakland Medical Group, P.C. reserves the right to change its notice and practices, in accordance with Section 164.520 of the Code of Federal Regulation. Should The Oakland Medical Group, P.C. change its notice, it will send a copy of any revised notice to the address I have provided (whether U.S. mail or, if I agree, email).

I wish to have the following restriction with regard to the use or disclosure of my health information:

____

____

____

I understand that as a part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I understand that this may include information relating to acquired immunodeficiency syndrome (AIDS) human immunodeficiency virus (HIV) infection, behavioral health service/psychiatric care and treatment for alcohol and/or drug abuse.

I fully understand and accept the terms of this consent.

____
Patient's Signature

____
Date

The following applies only if a restriction is added by Patient:

PRACTICE NAME

Accepts restriction	Does not accept restriction
______________________________	______________________________
Privacy Officer	Privacy Officer
______________________________	______________________________
Date	Date

FOR OFFICE USE ONLY

[ ] Consent received by ____________________ on ______________________.
[ ] Consent refused by patient, and treatment refused as permitted.
[ ] Consent card added to the patient's medical record on ______________________.

S:\Oakland Medical Group, P.C\General\Documents\Patient Consent to the Use & Disclosure.Oakland.doc