Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Dr. Scheiner originates and maintains paper and electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care. I understand that this information serves as:

--A basis for planning my care and treatment,
--A means for communication among the many health care 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 can verify that services billed were actually provided,
--And as a tool for assessing quality and reviewing the competence of healthcare professionals

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations.

I also understand that Dr. Scheiner is not required to agree to the restrictions I request. I understand that I may revoke this consent at any time in writing, except to the extent that the organization has already taken in reliance thereon.

I further understand that Dr. Scheiner reserves the right to change his notice and practices prior to implementation, in accordance with section 164.520 of the code of Federal Regulations. Should Dr. Scheiner change this notice, he will send a copy of any revised notices to the address I've provided.

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

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

_____

I fully understand and **accept / decline** the terms of the consent.

_____

Patient Signature Date