Consent to Use Protected Health Information

To provide for your healthcare **Dr. Brett Smith, HHP** collects information about your medical history, physical examinations and test results, diagnoses, and treatments. Use and disclosure of protected health information is regulated by a federal law known as The Health Insurance Portability and Accountability Act of 1996 (HIPPA). Under HIPPA, providers of healthcare may decide to obtain your consent to use personal health information for treatment, payment, or healthcare operations, but are not required to do so.

Therefore, I _____(printed name of patient or personal representative) consent that HHP may use the health information of (check one) □ myself or □specify _____for the following purposes (if signing as a personal representative, documentation of your legal right to do so must be provided).

1. Treatment (to perform actions required to help diagnose, maintain, or improve health)

2. Payment (to obtain reimbursement from third party payers)

3. Healthcare operations (to carry out, analyze, or improve business processes related to healthcare)

HHP has privacy practices that are summarized in our Notice of Privacy Practices for Protected Health Information (Notice). This Notice describes the use and disclosure of protected health information, patient's rights relevant to examining medical records, requesting corrections and additions to these records, requesting restrictions to the use of health information, finding out to whom their protected health information has been disclosed, and registering any complaints relevant to privacy issues. The Notice also describes how to receive these rights. I have been provided with or have previously received a copy of this Notice and given the opportunity to review it prior to signing this consent. I understand that if I decide not to sign this consent, **HHP** may decline to provide healthcare to me.

The consent I am signing today covers this and all future healthcare activities performed for me by **HHP** with respect to treatment, payment and operations. This consent replaces and supersedes any previous consents I may have sign with **HHP** for such use of my healthcare information. If I wish to revoke this consent, such a request must be made in writing. However, a revocation does not cover actions that have already been taken in reliance upon the consent previously in force. In addition, I understand that if I revoke this consent, then **HHP** may discontinue taking care of me.

Unless I object, my name, location, and general condition may be listed in a patient directory. Unless I object, my name and location may be disclosed to anyone asking for me by name. Unless I request otherwise, information about my health may be disclosed to other people involved in my healthcare (e.g. family members, personal representatives, those accompanying you for care). Unless I object, my religious affiliation may be disclosed to members of clergy.

I have the right to request restrictions or limitations as to how my protected health information will be used to carry out treatment, payment, or healthcare operations. I understand that HIPPA does not require such requests to be accepted, but if restrictions are accepted, then they must be honored. I request the following restrictions to the use and or disclosure of my health information: □ NONE or

□ Other:

Signature of Patient or Personal Representative Date Witness Date

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To be completed by DR. Brett Smith HHP

Printed Name	Title	Signature	Date

If restrictions are requested an individual authorized to approve such restrictions must sign.