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

HIPAA

I, _____, understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future treatment. I understand this information serves as:

- A basis for planning for care and treatment at C.O.R.E.
- A means of communication among the many health care professionals who contribute to my care.
- A source of information for applying my diagnosis and signal information to my bill.
- A means by which a third party payer can verify that services billed were provided.
- A tool for routine health care operations such as assessing quality and reviewing the competence of the healthcare professional.

I have been made aware of the Notice of Information Practices on file and I have the right to review that notice if I should desire.

The following persons listed are allowed to obtain treatment information and/or billing information associated with my treatment at C.O.R.E.

Spouse: Yes No Name_____ Parent: Yes No Name_____

Employer: Yes No Name_____ Child: Yes No Name_____

Other: Yes No Name_____ Child: Yes No Name_____

If I am unable to be reached, I give permission to have messages regarding my appointment time, changes thereof or schedule information left as follows: (circle those that apply)

Voicemail Email Text Message

At work With family member Answering machine

I fully understand and accept the terms of this consent.

Signature_____ Date_____
(Parent if a Minor)