Patient Consent to the Use and Disclosure of Health Information for Treatment Operations

I, _____, understand that as a part of my healthcare, Coolidge Imaging, LLC originates, maintains paper and/or electric records describing my health history, symptoms, examination and test result, diagnoses, and any plans for future care or treatment. I understand that this information serves 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 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 Coolidge Imaging, LLC Notice of Privacy Practices was posted in a clear and prominent place here 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 to disclosed to carry out treatment, payment, or health care options.

I understand that Coolidge Imaging, LLC 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 taken 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 if the Code of Federal Regulations.

I further understand that Coolidge Imaging, LLC reserves the right to change its notice and practices, in accordance with section 164.520 of The Code of Regulations. Should Coolidge Imaging, LLC change its notice, it will send me a copy of any revised notice to the address I have provided (whether U.S. mail or, if I agree, e-mail).

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

I understand that as 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 a disclosure for these uses, including disclosures via fax.

I fully understand and accept the terms of this consent.

Patient Signature_____Date_____

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

Parkwood Open Imaging accepts restriction

_____

Privacy officer Date

Does not accept restriction

_____

Privacy Officer Date

FOR OFFICE USE ONLY

{ } Consent received by_____On_____ { } Consent reused by patient, and treatment as permitted