BLUEFIELD WOMEN'S CENTER, P.C.

CONSENT TO USE, AND DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

PATIENT NAME:____

DATE OF BIRTH:______________ **SOCIAL SECURITY NUMBER:**______________________________________

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for care or treatment.

I understand that this information serves the following purpose:

- A basis for planning my care and treatment
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for application of my diagnosis and surgical information to my bill
- A mean by which a third-party payer can verify that services billed were actually provided
- A means of assessing routine healthcare operations

I further understand that I have the right:

- To object to the use of my health information for directory purposes
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations, and that the practice is not required to agree to the the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action In reliance on a previous request.

❑ I hereby request the following restrictions to the use or disclosure of my health information:

X____ ____________ ____

Signature of patient or legal representative **Date** **Witness**