

VASCULAR CLINIC

New Patient Consent to the Use and Disclosure of Health Information For Treatment, Payment, of Healthcare Operations

- I, _____, understand that as part of my health care, VASCULAR CLINIC originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care and 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 billed were actually provided
 - A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. 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
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that VASCULAR CLINIC 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 organizations 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 of the Code of Federal Regulations.

I further understand that VASCULAR CLINIC reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should VASCULAR CLINIC change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

INITIAL HERE

_____ I authorize the person(s) listed below to receive all health information about appointments, treatment and/or other information pertinent to my healthcare and/or payment for my healthcare provided at VASCULAR CLINIC.


INITIAL HERE

_____ I do not authorize the following information to be disclosed to any other parties except to me as the patient (Patient specify: _____

Please list **Name, Relationship to Patient and Phone Number of the Person** you are giving permission for VASCULAR CLINIC to release information to:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____

I fully understand and accept the terms of this consent.

Patient's Signature 

Date

FOR OFFICE USE ONLY

[] Consent received by _____ on _____

[] Consent refused by patient, and treatment refused as permitted.