Beckford Medical Center , PA

Consent to Treat and Privacy Practice

I, _____ understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examinations, test results, diagnoses, treatment, and any plans for future care and/or treatment. I understand that this information serve 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 professional.

_____ _____

Signature: ○Patient ○Parent ○Guardian ○Legal Representative **Date**

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

I hereby authorize use and/or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:_____

   _____

2. The following person/class of person/facility may receive disclosure of protected health information about me:

   _____

   (Name) *(Relationship)* *(Address)*

   _____

   (Name) *(Relationship)* *(Address)*

   _____

   (Name) *(Relationship)* *(Address)*

3. The specific information that should be disclosed is (please give dates of service if possible): _____

   _____

4. The purpose/use of the information is for: _____

   _____

(continued on next page)

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Initial all:

_____I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

_____I understand that the authorized health information may be electronically communicated.

_____I understand that medical records described above may include sensitive information such as, but not limited to, Workman's Comp, HIV/AIDS, psychologic diagnoses, or treatment for drug and alcohol abuse.

_____I understand and have been provided with a notice of Information Practices that provides a more complete description of information uses and disclosures, and will receive a copy of this form after I sign it.

_____I understand I may see and request a copy of the information described on this form if I ask for it and agree to pay any fees associated with copying of records.

_____I understand that I have the right to object to the use of my health information for directory purposes.

_____I understand that I have the right request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I wish to have the following restrictions to the use or disclosure of my health information: _____.

_____ I understand that the organization reserves the right to change its notice and practices and, prior to implementation, will mail a copy of any revised notice to the address I've provided.

_____ I understand I have the right to revoke this authorization, in writing addressed to the *Office Manager* at the address below. I understand that the revocation will not apply to information that has already been released in response to this authorization.

_____This authorization shall become effective immediately and will expire on the following date, event, or condition: _____.

_____ _____

Signature: ○Patient ○Parent ○Guardian ○Legal Representative **Date**

Printed name of patient's legal representative:_____

Relationship to patient:_____

Witness signature:_____ Date:_____

Office Manager
Beckford Medical Center, PA
176 S. Beckford Dr.
Henderson, NC 27536