## Consent Agreement

I, ________________________________________________ understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examinations, and test results, diagnosis, treatment, 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 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 the quality and reviewing the competence of health care professionals.

I have been informed by your notice of privacy practices containing a more complete description of the uses and discloses of my health information. (Available in the office in print form.)

I understand that I have the right to request restrictions as to how my health information may be used to disclose to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested.

I fully understand and accept the terms of this consent.

Signature: ______________________________________

Date: ______________