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**CONSENT AND AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION**

Patient Name (Print Name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consent: Federal regulations allow us to use or disclose protected health information from your record in order to provide treatment to you, to obtain payment for the services we provide, and for other professional activities known as “health care operations” (for example, quality improvement activities).

With this consent form, we are asking you make this permission explicit. By signing this consent, you are giving us permission to use or disclose your protected health information for these activities.

Authorization: This information is for the use or disclosure of your personal health information to: 1) Any insurance company or insurance adjuster involved in this case to receive payment for services provided. This will expire when paid in full for services rendered, 2) Any current or future attorney(s) representing you for this case to assist in the settlement of the case and to acquire payment for treatment when necessary. This will expire upon settlement of the case, 3) This authorization is also for adding your picture to our “Wall of Fame”. This will expire when the “Wall of Fame” is disassembled.

I hereby authorize the use or disclosure of my protected health information as specified above. I understand that this is a consent and authorization that is voluntary and that I may refuse to sign it. I understand that I may revoke this consent and authorization by giving written notification to my provider or any other member of the office staff. A revocation will not affect any action taken in reliance on the consent and authorization prior to revocation. Other limitations on my right to revoke this consent and authorization may be found in my provider’s Notice of Privacy Practices. I understand that, if the recipient is not a health care provider or health plan, the information disclosed under this consent and authorization may no longer be protected by federal privacy regulations and may be redisclosed by the recipient. I understand that I should receive a copy of this consent and authorization, even if I do not ask for it.

I understand that, I may ask you to restrict the use and disclosure of certain information in your record that otherwise would be allowed for treatment, payment, or health care operations. However, you do not have to agree to these restrictions. If you do agree to a restriction, the agreement is binding.

I understand that treatment may not be denied if I refuse to sign this consent and authorization, except: 1) If the authorization is the very reason for seeking the healthcare. (e.g., a pre-employment physical), that health care may be denied; or 2) If the authorization is for disclosure to research study, I may be denied the treatment that is part of the study. In addition, the following consequences might occur if I refuse to sign this authorization; (1) If the authorization is to demonstrate to a health plan that a service should be paid eligibility, the insurer may deny me the coverage I am seeking.

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Signature of Patient (or personal representative) Date