PATIENT HIPAA PRACTICE AGREEMENT

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 health care operations such as assessing quality and reviewing the competence

of health care professionals.

I understand and have been provided upon my request with a *Notice of lnformation 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 of lnformation Practices* prior to signing this consent.

The right to object to the use of my health information may be used or disclosed to carry out

Treatment, Payment, or Healthcare Operations.

I understand that FirstLine Medical 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 organization 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 FirstLine Medical reserves the right to change their Notice and Practices Prior to implementation, in accordance with section 164.520 of the Code of Federal Regulations. Should FirstLine Medical change his notice the office will provide me with a copy of the revised notice.

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another Physician, Insurance Company or Pharmacy of Patients choice.

PERMISSION TO RELEASE MEDICAL INFORMATION:

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize Firstline Medical to discuss and release all medical information to family members named below. This includes medical records, x-rays, history, findings and prognosis pertaining to the medical condition, services rendered, or treatment given to me.

Name Relationship

Name Relationship

Name Relationship

I FULLY UNDERSTAND AND ACCEPT THE TERMS OF THIS CONSENT

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(PATIENT/GUARDIAN SIGNATURE) (DATE)

OFFICE USE ONLY:

* CONSENT RECEIVED IF SIGNED ABOVE.
* CONSENT REFUSED BY THE PATIENT.