# WOODS FAMILY MEDICINE

ABBEY L. WOODS, MD

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

I understand that as part of my health and medical care, Woods Family Medicine originates and maintains medical and health records describing my health history, symptoms, examinations and test results, diagnosis, treatment and any plans for future care of treatment.

I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the health professionals who contribute to my care
- A source of information for applying my diagnosis and treatment for my bill.
- A means for a third-party payer to verify that services were billed as actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

- I further understand and agree that this agreement to release information shall apply to all information accumulated up to this date and any information acquired in the future. This agreement to release future information shall remain in force until such time as I shall revoke it in writing.
- I understand and have been offered a PATIENT PRIVACY NOTICE that provides a more complete description of information used and disclosures. I understand that I have the right to review the PATIENT PRIVACY NOTICE prior to signing this consent. I understand that Woods Family Medicine reserves the right to change their notice and practices, and I will have the right to review the policy at any time. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and Woods Family Medicine is not required to agree to the restrictions requested.
- **I understand that I may revoke this consent in writing, except to the extent the organization has already taken action upon. This notifies you that the information authorized for release may include records, which may indicate the presence of a communicable, or venereal disease, which may include, but are not limited to: diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus (also known as acquired immune deficiency syndrome, AIDS).**
- **Appointment date and time information will be left on your answering machine and/or voicemail unless you specify otherwise.**

Information may be released to the following named individuals (i.e. parent, spouse, sibling, friend, etc.):

_____

_____

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

_____

_____

**Signature of Patient or Legal representative**

_____Date notice effective _____

**Woods Family Medicine [accepts, denies, accepts conditionally] the restrictions imposed on release of information stated above.
Signature of Woods Family Medicine Employee

_____Date notice effective _____

**This form is being provided to meet HIPPA requirements Signature on File

**Please read the following and sign at bottom:**

**I authorize use of this form for all my insurance submissions.
**I authorize release of information to all my insurance companies.
**I understand that I am responsible for any balance my insurance does not pay.
**I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.
**I authorize payment directly to my doctor.
**I permit a copy of this authorization to be used in place of the original.

Signature: _____ Date: _____