Hope Medical Clinic P.A

3609 Cape Center Drive, Fayetteville, NC 28304
Phone: 910.500.0909 Fax : 910.920.4224

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations/Receipt of Notice of Privacy Practices

I, _____, understand that as part of my health care, **Hope Medical Clinicc P.A** originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and 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 and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a ***Notice of Privacy 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 prior to signing this consent,
- The right to amend my health information, and
- The right to request restrictions as to how my health information may be used and/or disclosed to carry out treatment, payment, or health care operations, or disclosed to family members and others involved in my care.

I understand that **Hope Medical Clinic P.A** 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 take 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 **Hope Medical Clinic P.A** reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should **Hope Medical Clinic P.A** change their notice, they will post the revised copy in the reception area at the office and provide a copy to me at my request.

I understand and agree that Hope Medical Clinic P.A may contact me at my home, cell phone or work number provided concerning appointments and other relevant medical information as further described in their Notice of Privacy Practices.

I wish to have the following restrictions to the use or disclosure of my health information and/or alternate communications:

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_____

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 entity, and I consent to such disclosure for these permitted uses, including disclosures via fax, telephone or mail.

I fully understand and ☐ Accept / ☐ Decline the terms of this consent.

_____ _____

Patient's Signature Date

Revision Number/Date (If Applicable): _____/_____