TODD MOFFATT, M.D. SURGERY

Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as a part of the provision of healthcare services, Todd Moffatt Surgery creates and maintains health records and other information describing among other things, my health history, symptoms, examination, and test results, diagnoses, treatment, and any plans for future care of treatment.

I have been provided with Notice of Privacy Practices that provides a more complete description of the use and disclosures of certain health information. I understand that I have the right to review the notice prior to signing consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. 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 health operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, ect.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already made reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used to disclosed for the purposes of treatment, payment or health care operations be restricted. I also understand that the Practice and I must: agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information which have been previously agreed upon.

_____ _____

(PATIENT'S NAME PRINTED) DATE

_____ _____

PATIENT'S SIGNATURE (OR GUARDIAN, IF A MINOR) SOCIAL SECURITY NUMBER

I AUTHORIZE INFORMATION TO BE RELEASED TO:

NAME _____ RELATION _____

NAME _____ RELATION _____