Center for Orthopaedic Surgery and Sports Medicine

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PRIVACY NOTICE

New Patient Consent to the Use and Disclosure of Health Information For Treatment, Payment or Healthcare Operations

I, _____, understand that as part of my health care, Center for Orthopaedic Surgery and Sports Medicine originates and maintains the paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plan 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 many health professionals who continue 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 the 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 that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

I understand the Center for Orthopaedic Surgery and Sports Medicine is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, expect to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing the sign this consent or revoking consent, this organization may refuse to treat me as permitted by Section 164.520 of the Code of Federal Regulations.

I further understand that the Center for Orthopaedic Surgery and Sports Medicine reserves the right to change their notice and practices and prior implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should the center for Orthopaedic Surgery and Sports Medicine change their notice, they will provide me a copy of any revised notice to the address I've provided.

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.

☐ *I fully understand and accept.* ☐ *I decline the terms of this consent.*

I have the opportunity to review this office Notify of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document should I request.

_____ ____ / ____ / _____

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE **DATE**