# Consent for Use or Disclosure of Health Information Form

As a patient of this practice I understand that it is necessary for records to be maintained, whether they be electronic or paper, that contain my personal history, test results, diagnosis, laboratory results and all other information pertaining to my care. I understand that this is necessary to allow the provider to do the following:

- Plan my treatment
- Consult Specialists
- Receive payment for services rendered
- Have proof of services provided
- As a measure of customer service

I have been given a copy of the Notice of Patient Privacy Information Practices and understand that I have the right to:

- Review notice of privacy prior to consent
- Restrict how my information is used for treatment, payment, and healthcare operations
- Place restrictions on or revoke the use of my health care information

## Restrictions:

I request that the following restrictions be placed on my file for disclosure purposes:_____
_____

The office may discuss information regarding treatment and payment for services with the following people:
_____

***Message or Appointment Reminders:***

May we contact or leave a message at home#( ) cell#( ) e-mail( ) not at all( ).

May we leave a message at home with someone else? Yes ( ) No ( )

If Yes, who?_____

I understand at times it is necessary to disclose my information for payment, test, surgery, and other procedures that this office needs to continue my care as permitted under state and federal law.

**I fully understand and accept the information provided in this consent form.**

_____ _____ _____
Patient Signature Printed Name Date

PATIENT AUTHORIZATION FOR PROVIDER'S ACCESS, USE AND DISCLOSURE
OF RECORDS AND/OR PROTECTED HEALTH INFORMATION
THROUGH JACKSON COMMUNITY MEDICAL RECORD, L3C

_____JCHC_____ ("Provider") is participating in a community wide electronic health record system ("EHR System") established by Jackson Community Medical Record L3C ("JCMR") and has obtained a Sub-License to use the EHR Software. This means that my Provider will create an individual electronic health record for me in the JCMR EHR System which consists of my private health information ("PHI") which will be available electronically to my Provider and other healthcare Providers and their respective Permitted Users for purposes of providing healthcare services to me including treatment, payment and other healthcare operations. Examples of PHI include but are not limited to my name, address, insurance information, payment history, social security number, laboratory and other diagnostic test results or reports, medications, medical history, surgery information, immunization records and any notes kept by my Provider or the Provider's office related to my care. In order to create the EHR for me, my Provider and his Permitted Users will be required to disclosed my PHI to JCMR, who operates and maintains the community wide EHR.

CONSENT TO ACCESS, USE OR DISCLOSE OF PROTECTED HEALTH INFORMATION.

I understand that it is the intent of Provider to hold all of my individually identifiable health information (medical information or "PHI") with the utmost level of confidentiality. I authorize and give consent to my Provider, his/her/its Permitted Users, to create and use an EHR which includes disclosing my PHI to JCMR and other healthcare Providers who provide me with healthcare services, for my continuing care and treatment, payment, healthcare operations, and as described in each Provider's Privacy Notice. This includes my consent and authorization for the release and disclosure of any medical information necessary to process insurance claim(s) on my behalf. I also authorize payment of medical health insurance benefits to be made directly to Provider and/or his/her/its designees for services rendered.

AUTHORIZATION FOR ACCESS TO JCMR MEDICAL RECORD AND RELEASE OF INFORMATION.

If a JCMR EHR has already been created for me, I consent and authorize Provider and his/her/its Permitted Users to access my JCMR EHR for my continuing care and treatment, payment or healthcare operations. This includes my consent and authorization for the release and disclosure of any medical information necessary to process insurance claim(s) on my behalf. I also authorize payment of medical health insurance benefits to be made directly to Provider and/or his/her/its designees for services rendered.

I have read this form in its entirety or have had it read to me. Additionally, I have had the opportunity to ask any questions that I may have and they have been answered to my satisfaction.

Patient Signature: _____Date: _____

Parent/Guardian Signature: _____ Date: _____

Printed Name and Address of Patient: _____