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

Patient's Name: ___________________________________ **Date of Birth:** _____________________

I understand that, as part of my health care, the Cobb and Douglas County Boards of Health originate and maintain health 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 treatment 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 have been provided with a *Notice of Provider Privacy Practices* that provides a more complete description of information uses and disclosures.

I understand that:

- I have the right to review the notice prior to signing this consent.
- The organization reserves the right to change its notice and practices.
- I will receive a revised notice at my next visit if any revisions are made to the notice.
- I have the right to object to the use of my health information for directory purposes.
- 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 care operations, and that the organization is not required to agree to the restrictions requested.
- I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

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

____

____

____

____

____

____	_____________________	_____________________
Signature of Patient or Patient's Legal Representative	**Relationship to Patient**	**Date**

____	_____________________	_____________________
Witness	**Title**	**Date**