MULTICARE HEALTH CENTER
3842-44 HARLEM AVENUE
LYONS, IL 60534
(708) 442-3050

PATIENT CONSENT TO THE USE & DISCLOSURE OF HEALTH INFO FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS & ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I, _____, understand that as part of my health care, paper and/or electronic records are originated and maintained describing my health history, symptoms, examination ad 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.
- Means of communication among the many health professionals who contribute to my care.
- Source of information for applying my diagnosis and surgical information to my bill.
- Means by which a third-party payer can verify that services billed were actually provided.
- Tool for routine healthcare operations such as assessing quality & reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Information 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 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 that it 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 taken 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 the right is reserved to change this notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should the notice be changed, they will send a copy of any revised notice to the address I've provided (whether U.S. mail, or, in agree, email).

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

_____

_____

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 / DECLINE** the terms of this consent. (Must circle one)

I **CONSENT / REFUSE** to be treated. (Must circle one)

Patient's Signature: _____ Date: _____

I have been presented with a copy of the "Notice of Health Information Practices" detailing how my information may be used and disclosed as permitted under federal and State law. I understand the contents of the Notice, and I request the following restriction (s) concerning the use of my personal medical information:

_____

_____

I also understand that in order to file insurance benefits on my behalf, it will be necessary to release information regarding the medical treatment that I have received.

Signed:_____**Date:**_____

Please Print Name Here: _____ **Witnessed By:**_____