



**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, Sports Reaction Center originates and maintains paper and/or electronic 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 including phone message notification to you about appointments;
- A means of communication among the many health professionals who contribute to 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 services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and 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 and
- 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 Sports Reaction Center 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 Sports Reaction Center reserves the right to change their notice and practices in accordance with Section 164.520 of the Code of Federal Regulations. Should Sports Reaction Center changes their notice, I will receive a revised notice at the next visit.

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 or electronically.

I fully understand and **accept** / **decline** (select one) the terms of this consent.

EXCEPTION

Patient’s Signature

NAME
RELATIONSHIP TO PATIENT
FULL ACCESS TO ALL?

Date

FOR OFFICIAL USE ONLY

Consent received by _____ on _____

Consent refused by patient, and treatment refused as permitted.

Consent added to the patients medical record on _____