

# 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, David R. Benson, M.D., O.D., PLLC, originates and maintains paper and/or electronic records describing my personal history, health history, symptoms, examination, test results, diagnoses, treatment, and plans for future care and treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among 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,
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I have been offered a "Notice of Information Practices" that provides a more complete description of information uses and disclosures and 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, and
- The right to request restrictions as to how my health information may be used or disclosed for aiding in treatment, payment, or health care operations but that David R. Benson, M.D., O.D., PLLC, 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.
- If I refuse to sign this consent or revoke this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.
- As part of this organization's treatment, payment or health care operations, it may be necessary to disclose my protected health information to another entity. I expressly give consent for such disclosure, including facsimile.

I further understand that David R. Benson, M.D., O.D., PLLC, reserves the right to change their notices and practices at any time, in accordance with Section 164.520 of the Code of Federal Regulations. Should David R. Benson, M.D., O.D., PLLC, change their notice they will post such notice at their place of business.

I wish to have the following restrictions to the use or disclosure of my health information: (none if not filled in): \_\_\_\_\_

I give permission for my health information to be shared, including by telephone, also with the people who identify themselves as (none unless filled in):

(1) \_\_\_\_\_ Relationship: \_\_\_\_\_ (3): \_\_\_\_\_ Relationship \_\_\_\_\_

(2) \_\_\_\_\_ Relationship: \_\_\_\_\_ (4): \_\_\_\_\_ Relationship \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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Office Use Only    Consent received by: \_\_\_\_\_  
                          Consent refused by patient and treatment refused as permitted \_\_\_\_\_  
                          Consent added to patient's chart on \_\_\_\_\_