PARTNERS MEDICAL CLINIC
Partnership in Healthcare
431 South Fifth Street
Gadsden, Alabama 35901
Phone: (256) 547-3822 Fax: (256) 547-3822

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

I, _____ understand that as part of my healthcare, this practice **Partners Medical Clinic, LLC** originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and 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 care professionals who may 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.
- 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 right to review the Notice prior to signing this consent. I understand that **Partners Medical Clinic, LLC** reserves the right to change its notice and practices. A copy of any revised notice will be mail to the address I have provided prior to implementation. I understand that I have the right to object to the use of health care information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that **Partners Medical Clinic, LLC** is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that **Partners Medical Clinic, LLC** has already taken action in reliance thereon.

I wish to have the following restrictions to the use of my health information.

_____

_____

_____

I fully understand and accept / decline the terms of this consent.

Signed: _____ Date: _____