New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operation.

I, _____ DOB:_____
Understand that as part of my health care, Pulmonary & Critical Care Specialist originates in maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for a 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 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 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 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 operation.

I understand that Pulmonary & Critical Care Specialist is not required to agree with 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 Pulmonary & Critical Care Specialist reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Pulmonary & Critical Care Specialist change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

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

I wish the following people to be provided with my health information upon request:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that as part of this organization's treatment, payment, or healthcare 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 acknowledge and provide consent to Pulmonary & Critical Care Specialist and Novi & Sleep Diagnostic Center to prescribe medications and send my prescriptions electronically.

I acknowledge and provide consent to Pulmonary & Critical Care Specialist and Novi & Sleep Diagnostic Center to obtain information from my insurance provider electronically.

I acknowledge that Pulmonary & Critical Care Specialist and Novi Sleep & Dignostic Center has an electronic medical record and patient management system in which my health information will be shared electronically with my primary care physician, referring physician, insurance carrier (as required under the terms of our service contract with your insurance provider), upon request by subpoena, and/ or other circumstances required by the physicians to provide appropriate care to the patient or as mandated by state or federal law.

I fully understand and accept the terms of this consent. Any and all questions I have regarding this consent have been answered to my satisfaction.

_____ _____

Patient's signature Date

_____ _____

Patient Refusal for Consent to use PHI **Date**

_____ _____

Witness **Date**

For office use only

[ ] Consent received by_____ On_____

[ ] Consent ***REFUSED*** by patient, and treatment refused as permitted.

[ ] Consent added to the patient's medical record on: _____