JOEL H. MCGAHEN, OD PC
112 W. Main Street, Waynesboro, PA 17268
422 Phoenix Dr., Chambersburg, PA 17201

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

Patient Name:_____
Date of Birth: _____

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, payment for our services, and to conduct health care operations involving our office.

We have a comprehensive NOTICE OF PRIVACY PRACTICES that describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this consent document. As described in our NOTICE OF PRIVACY PRACTICES, the use and disclosure of your health information for treatment purposes not only includes care and services provided here, but any information that may be necessary or appropriate for you to receive follow up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes our submissions of your health information to a billing agent or vendor for processing claims or obtaining payment; our submission of claims to third party payers or insurers of claim review, determination of benefits and payment; our submission of your information to auditors hired by third party payers and insurers, among other aspects of payment described in our NOTICE OF PRIVACY PRACTICES will be updated whenever our privacy practices change. You can get an updated copy here at the office or from our web site.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform health care operations. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent. We can decline to serve you if you elect not to sign this consent form.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment, or health care operations, but as described in our NOTICE OF PRIVACY PRACTICES, we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our NOTICE OF PRIVACY PRACTICES describes how to ask for a restriction.

I HAVE READ AND UNDERSTAND THIS FORM. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

Dated _____ **Patient** _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form.

Relationship to patient: _____ Print Name: _____

Source of Authority: _____