MEESE, TOLLAND, RITTER, & WILLIAMS, PA/VESC
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, Meese, Tolland, Ritter, and Williams, PA originates and maintains paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnosis, treatment, and any plans for further care or treatment.

I understand this information serves as:

- A basis for planning my care and treatment,
- A means of communications 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 compete 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,
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations

I understand Meese, Tolland, Ritter, and Williams, PA 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 in Section 164.506 of the Code of Federal Regulations.

I further understand that Meese, Tolland, Ritter, and Williams PA, reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should we change our notice, we will send a copy of any revised notice to the address I've provided.

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

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_____

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 used, including disclosure via fax.

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

Patient Signature _____ Date _____ (10.14)