FALL CREEK
INTERNAL MEDICINE

2160 NE WILLIAMSON COURT
BEND, OREGON 97701

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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, Fall Creek Internal Medicine originates and maintains paper and/or electronic records describing my health history, symptoms, examination and tests results, diagnoses, treatment, and any plans for future care of 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 and/or insurance claim
- 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 Privacy 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 and notice prior 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 operations.

I understand that Fall Creek Internal Medicine 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 by Section 164.506 of the Code of Federal Regulations.

I further understand that Fall Creek Internal Medicine 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 Fall Creek Internal Medicine change their notice, they will send a copy of any revised notice to the address I've provided (whether in U.S. mail or, if I agree, email).

I understand that as part of this organization's treatment, payment, or health care 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.

DOUBLE SIDED FORM, SEE REVERSE

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

_____
_____
_____

This authorization permits Fall Creek Internal Medicine to send protected health information to the hospital, Home Health Care Agencies, Nursing Homes, Assisted Living facilities and Pharmacies as needed to provide medical treatment and prescriptions via fax, email or U.S. mail.

Additionally, please list below any relative, friend or caregiver you AUTHORIZE Fall Creek Internal Medicine to disclose your protected health information and/or account information to. This would include picking up any medical reports, written prescriptions or drug samples. Be sure and list full name, relationship, and phone number in the space provided below.

First & Last Name	Relationship to Patient	Phone Number

You, the patient have the right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable during a contestability period. In order for the revocation of this authorization to be effective, Fall Creek Internal Medicine must receive the revocation in writing. The revocation must include:

- The patient's name, address, and patient number, if applicable
- The effective date of this authorization, and the recipients of this protected health information according to this authorization
- The patient's desire to revoke this authorization.
- The date of the revocation, and the patient's signature

Fall Creek Internal Medicine will accept written revocations of this authorization via:

- Certified U.S. mail
- Facsimile at (541) 389-2662

I fully understand and accept the terms of this consent.

_____ _____
Patient's Signature Patient's Name (Please Print)

_____
Date

FOR OFFICE USE ONLY
Consent added to the patient's medical record on _____