

IRMC Physician Group (IPG)
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, IPG originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any 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 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 have been provided with *IRMC Physician Group Privacy Standards Notice of Health 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 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 IPG 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 take action in reliance upon this consent. I may deliver my revocation by any means I choose (e.g. personally or by mail). 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 IPG 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 IPG 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 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.

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

Patient's Signature

Signature if you are the Patient's Representative

Date

Describe your Authority

Print Representatives Name

This consent may be combined with the informed consent as long as it is visually or organizationally separate, and separately signed and dated. See 45 CFR 164.506(b)(4).
The intent is that this should be a joint consent within an integrated care setting, so that medical staff members and others need not obtain separate consents for