

## Consent for Treatment, Payment, and Healthcare Operations

I consent to the use or disclosure of my protected health information by East Lincoln Family Health Professionals, PC for the purpose of diagnosing or providing treatment to me, to obtain payment for my health care bills, or to conduct health care operations of East Lincoln Family Health Professionals, PC. I understand that diagnosis or treatment of me by East Lincoln Family Health Professionals, PC may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or health care operations of the practice. East Lincoln Family Health Professionals, PC, is not required to agree to the restrictions that I request. However, if East Lincoln Family Health Professionals, PC agrees to a restriction that I request, the restriction is binding on East Lincoln Family Health Professionals, PC.

I have the right to revoke this consent in writing, at any time, except to the extent that East Lincoln Family Health Professionals, PC has taken action in reliance on this consent.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my health care provider, a health care professional, a health plan, my employer, or a healthcare clearinghouse. This protected health information related to my past, present, or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review East Lincoln Family Health Professionals, PC Notice of Privacy Practices and the Patients Services and Rights Agreement prior to signing this document. A copy of the East Lincoln Family Health Professionals, PC Notice of Privacy Practices and the Patients Services and Rights Agreement is available upon request. A copy of the afore-mentioned documents will also be provided to me upon my request. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or the performance of healthcare operation of East Lincoln Family Health Professionals, PC.

East Lincoln Family Health Professionals, PC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office requesting a revised copy to be sent by mail or asking for a copy at the time of my next appointment.

*Acknowledgement Signature Required on Demographic Form.*