

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, Montana Orthopedics creates and maintains health records describing my health history. I understand that the Clinic may use this information as a:

1. Basis for planning my care and treatment;
2. Method of communication among many health professionals who contribute to my care;
3. Means by which third-party payors can verify that services billed were actually provided; and
4. Tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I have been made aware of Montana Orthopedics' Notice of Privacy Practices, which provides a description of potential uses and disclosures of my health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the Clinic reserves the right to change its notice and practices. If the Clinic changes the notice, I can obtain a revised copy from the Clinic. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or other healthcare operations. However, the Clinic is not required to agree to the restrictions requested. If the Clinic does agree to such restrictions, it must comply with such restrictions. I understand that I may revoke this consent in writing, except to the extent that the Clinic has already taken action in reliance on it.

I request the following restrictions to the use or disclosure of my health information.

Patient Name: _____

Signature of patient or patient's representative

Date: _____

Printed name of patient's representative: _____

Relationship to patient: _____