**Southwest Internal Medicine Group**
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# PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: ____/____/____

SSN: _____-_____-_____ Previous Name: _____

I understand that my/the patient's health information is private and confidential. I understand that Southwest Internal Medicine Group works hard to protect my/the patient's privacy and preserve the confidentiality of my/the patient's health information.

I understand that Southwest Internal Medicine Group may use and disclose my/the patient's health information to provide treatment to me/the patient, to handle billing and payment, and to take care of other healthcare operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. An example may be if a patient is a danger to self or others.

Southwest Internal Medicine Group has a detailed document called the "Notice of Privacy Practices for Protected Health Information". It contains more detailed information on how we may use and disclose the patient health information. I understand that I have a legal right to read the "Notice" before I sign this consent.

Southwest Internal Medicine Group may update this "Notice of Privacy Practices for Protected Health Information" at any time and without prior notice. If I ask, Southwest Internal Medicine Group will provide me with the most current "Notice of Privacy Practices for Protected Health Information".

Under the terms of this consent, I can ask Southwest Internal Medicine Group to restrict how my/the patient's health information is used or disclosed to carry out treatment, payment or healthcare operations. I understand that Southwest Internal Medicine Group does not have to agree to my/the patient's request. If Southwest Internal Medicine Group does agree to my/the patient's request, I understand that Southwest Internal Medicine Group will follow the agreed limits.

I may cancel this consent in writing at any time by doing one of the following:

1) Signing and dating a form that Southwest Internal Medicine Group can give me called "Revocation of Consent for Use and Disclosure of Healthcare information";

OR

2) Writing, signing, and dating a letter to Southwest Internal Medicine Group. If I write a letter, it must say that I want to revoke my/the patient's consent to authorize the use and disclosure of my/the patient's health information for treatment, payment and healthcare operations.

If I revoke this consent, Southwest Internal Medicine Group does not have to provide any further healthcare services to me/the patient.

My signature below indicates that I have been given the chance to review a current copy of Southwest Internal Medicine Group's "Notice of Privacy Practices for Protected Health Information". My signature means that I agree and consent to allow Southwest Internal Medicine Group to use and disclose my/the patient's protected health information to carry out treatment, payment, and healthcare operations.

_____ _____ _____
Patient or legally authorized individual signature Date Time

_____
Relationship to patient if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)