

**Consent for Purposes of Treatment, Payment and Healthcare Operations**

I consent to the use or disclosure of my protected health information by United Regional Physician Group Orthopaedic Services for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of United Regional Physician Group Orthopaedic Services. I understand that diagnosis or treatment of me by United Regional Physician Group Orthopaedic Services 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 healthcare operations of the practice. United Regional Physician Group Orthopaedic Services is not required to agree to the restrictions that I may request. However, if United Regional Physician Group Orthopaedic Services agrees to a restriction that I request, the restriction is binding on United Regional Physician Group Orthopaedic Services.

I have the right to revoke this consent, in writing, at any time, except to the extent that United Regional Physician Group Orthopaedic Services 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 physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I UNDERSTAND THAT MY MEDICAL RECORDS MAY CONTAIN INFORMATION THAT INDICATES THAT I HAVE A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT IS NOT LIMITED TO, DISEASE SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, OR THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). With this knowledge, I give my consent to the release of all information in my medical records including any information concerning my identity.

NOTICE TO PATIENTS: Information in your medical record that you have or may have a communicable or venereal disease is made confidential by law and cannot be released without your permission except in limited circumstances including release to persons who have had risk exposures, release pursuant to an order of the court, or the Department of Health, release among health care providers or release for statistical or epidemiological purposes. When such information is released, it cannot contain information from which you could be identified unless release of that identifying information is authorized by you, by an order of the court or the Department of Health, or by law.

I understand I have a right to review United Regional Physician Group Orthopaedic Services Notice of Privacy Practices prior to signing this document. The United Regional Physician Group Orthopaedic Services Notice of Privacy Practices has been provided to me. 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 in the performance of healthcare operations of the United Regional Physician Group Orthopaedic Services. The Notice of Privacy Practices for United Regional Physician Group Orthopaedic Services is also posted in the main waiting area of the office. This Notice of Privacy Practices also describes my rights and the United Regional Physician Group Orthopaedic Services duties with respect to my protected health information.

United Regional Physician Group Orthopaedic Services 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 and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

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**Signature of Patient** or Personal Representative

\_\_\_\_\_  
**Date Notice Effective**

\_\_\_\_\_  
**Print Name of Patient** or Personal Representative

\_\_\_\_\_  
Description of Personal Representative's Authority

\_\_\_\_\_  
**Employee Signature**