HIPAA Privacy Rule Individual Consent Agreement

Consent to Use and Disclosure of Protected Health Information For Treatment, Payment, or Healthcare Operations (§164.506(a))

I, _____understand that as part of my health care, Fertility and Surgical Medical Associates of California originates and maintains health 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 health professionals who may contribute to my health 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 health care operations such as assessing quality and reviewing the competence of the health care professional.

I have been provided with and understand that Fertility and Surgical Medical Associates of California's ***Notice of Privacy Practices*** provides a more complete description of the information.

I understand that:

- I have the right to review Fertility and Surgical Medical Associates of California's Notice of Privacy Practices prior to signing this consent;
- That Fertility and Surgical Medical Associates of California reserves the right to change their notice and practices prior to implementation and will mail a copy of any revised notice to the address I have provided;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Fertility and Surgical Medical Associates of California is not required by law to agree to the restrictions requested.
- I may revoke the consent in writing at any time, except to the extent that Fertility and Surgical Medical Associates of California has already taken action in reliance thereon.

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

_____

_____

_____

[ ] Accepted [ ] Denied Date: _____

Signature of Individual or Legal Representative Witness: _____

Social Security Number: _____ Date of Birth: _____

Printed Name of Individual or Legal Representative Witness: _____