



**MERCY MEDICAL ASSOCIATES -KY
PATIENT CONSENT TO USE & DISCLOSE HEALTH INFORMATION FOR
TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS**

Patient Name: _____ **Date of Birth:** _____

I understand that as part of my health care, Mercy Medical Associates –Ky, their practices and providers, originates and maintains paper and/or electronic 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 my other health care professionals
- A source of information for submitting medical claims for payment
- A means by which a payer can verify rendered

I understand and have been given a *Notice of Privacy Practice* that provides a more complete description of health information uses and disclosures, as well as my rights regarding the use and disclosure of my health information.

I understand that Mercy Medical Associates – Ky, their practices and providers, is not required to agree to any restrictions requested and I may revoke this consent in writing. Such revocation will not apply to authorized uses and disclosures made prior to the revocation.

I also understand that by refusing to sign this consent or revoking this consent, this practice may refuse to treat me as permitted by Section 164.506 of the *Code of Federal Regulations*.

I understand Mercy Medical Associates – KY, their practices and providers reserve the right to change the notice and practices prior to implementation in accordance with Section 164.520 of the *Code of Regulations*. Should the notice be changed, the practice will send a copy of any revised notice to the mailing address I have provided.

I understand health information may be used or disclosed by mail, telephone, electronic means, and by fax. I authorize the use or disclosure of my health information for purposes of treatment, payment, or healthcare operations to other health care professionals involved in my care/treatment, insurance, third-party payers, pharmacies, and the following relative(s) and/or others:

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

I wish to have the following restrictions placed on the use and disclosure of my health information:

I fully understand and **accept** the terms of the consent:

Patient's Signature

Date

Relationship if other than patient