

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

NAME _____
BIRTHDATE _____

I understand that as part of my healthcare, Brett Csordas L.Ac. originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and medical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of the healthcare professional.

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 healthcare operations – and that Brett Csordas L.Ac. is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

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

Patient:

X _____
Patient Signature or Legal Representative Date

Office Use Only:

↑ Accepted _____
↑ Denied **Signature** **Title** **Date**