BW Arthritis & Rheumatology
Healthy Joints, Healthy Bones

Patient Consent

I, _____, understand that as part of my, healthcare, BWAR 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 the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can testify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing the quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Privacy Practices* that provides more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my heath information may be used or disclosed to carry out treatment, payment, or healthcare operations.

I understand that BWAR office is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations

I further understand that BWAR reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.506 of the Code of Federal Regulations. Should BWAR change their notice, they will provide a copy of any revised notice.

I understand that as part of this organizations treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept/decline the terms of this consent.

_____ _____/_____/_____
Patient Signature **Today's Date**

Who else do you give authorization to receive your medical information?

Name: _____ **D.O.B:** _____/_____/_____
Relationship: _____
Address: _____
Tele: (_____)-_____-_____

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