# Patient Consent for Physician to Use or Disclose Health Care Information for Treatment, Payment and Health Care Operations

**Patient's Name:**______________________________

**Chart #**________________

**DOB:**___________________

**SSN:**_________________________________

I understand that my health information is private and confidential. I understand that **Bon Sain** works very hard to protect my privacy and preserve the confidentiality of my personal health information.

I understand that signing this document means that **Bon Sain** may use and disclose my personal health information to help provide health care to me, to handle billing and payment, and to take care of other health care operations. Failure to sign this consent may result in the physician declining to treat me.

**Bon Sain** has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices used to protect their patients' privacy. I understand that I have the right to read the "Notice" before signing this agreement.

**Bon Sain** may update this "Notice of Privacy Practices". If I ask, **Bon Sain** will provide me with the most current "Notice of Privacy Practices".

Under the terms of this consent, I can ask **Bon Sain** to restrict how my personal health information is used or disclosed to carry out treatment, payment, or health care operations. I understand that **Bon Sain** does not have to agree to my request. If **Bon Sain** does agree to my request, I understand that **Bon Sain** would follow the agreed limits.

I understand that I have the right to cancel this consent in writing, at any time. If I do cancel the consent, I understand that **Bon Sain** may have already used or disclosed information about me and canceling this consent would not effect the information already used or disclosed.

I may cancel this consent at any time by doing one of the following:

1) Signing and dating a form that **Bon Sain** can give me called "Revocation of Consent for Use and Disclosure of Health Care Information"; or

2) Writing, signing, and dating a letter to **Bon Sain**. If I write a letter, it must say that I want to revoke my consent to authorize the use and disclosure of the patient's personal health information for treatment, payment, and health care operations.

I understand if I cancel this consent, **Bon Sain** does not have to provide any further health care services to me.

My signature below indicates that I have been given the chance to review a current copy of Bon Sain's “Notice of Privacy Practices”.

_____________________________________________Date_________________
Patient or legally authorized individual signature

_____________________________________________Date__________________
Relationship to patient if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)

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Please list any individual who you will allow to make inquiries about your health information:

___________________________________ ___________________________________

___________________________________ ___________________________________

___________________________________ ___________________________________

___________________________________ ___________________________________