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HarvardFamilyMedicine.com

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my health and medical care, **Harvard Family Medicine** originates and maintains medical and health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment.

I further understand that this information serves as:

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

I further understand and agree that this agreement to release information shall apply to all information accumulated up to this date and to any information acquired in the future.

I understand and have been provided with a **PATIENT PRIVACY NOTICE** prior to signing this consent. 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. I understand that I may revoke this consent in writing, except to the extent **Harvard Family Medicine** has already taken action in reliance thereon.

This agreement to release future information shall remain in force until such time as I shall revoke it in writing.

By law, we are required to notify you that the information authorized for release may include records which may indicate the presence of a communicable or venereal diseases which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus also known as AIDS.

Information may be released to the following organizations:

Insurance Company: ______________________________

Family Member: ______________________________

Other: ______________________________

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

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You ☐ **may** or ☐ **may not** leave medical information on my message service or answering machine.

Please contact me at the following numbers: Home:____________________ Work:____________________

I hereby authorize and request payment of benefits to the provider of services. I understand I am financially responsible to **Harvard Family Medicine** for charges not covered or denied by my insurance company.

______________________________ Signature of Patient or Legal Representative

______________________________ Date

Revised 03/13