Robin C. Wedberg, M.D.

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

I understand that as part of my healthcare, this organization originates and maintains health 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 verify that services billed were actually provided
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

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

- I understand that I have the right to review the notice prior to signing this consent.
- I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided.
- I understand that I have the right to object to the use of my health information for directory purposes.
- 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 the organization 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 thereon.
- I understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me.

With my consent, Robin C. Wedberg, M.D., APC may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as any call pertaining to my clinical care, including laboratory results among others (this does not include leaving detailed messages of the results of test, only that we are calling regarding tests- unless specified by the patient).

With my consent, Robin C. Wedberg, M.D., APC, may mail to my home or other designated location any item that assists the practice in carrying out TPO.

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

Signature of Patient or Legal Representative Witness

Signature_____

Date: _____