CONSENT AGREEMENT to Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations according to the guidelines of the Federal Health Insurance Portability and Accountability Act (HIPAA)

I understand that as part of my health and medical care, Dr. Grellet and her associates originate and maintain medical and health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I further understand that this information serves as:

1. A basis for planning my care and treatment
2. A means of communication among health professionals who contribute to my care
3. A source of information (my name, date of birth, address including Zip code, telephone number, insurance information, etc.) for applying my diagnosis and treatment information to insurance companies to assist for reimbursement/payment of my bill and to allow for pre-authorization for services and medications
4. A means for a third-party payer to verify that services were billed as actually provided
5. A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals
6. A means for allowing prescriptions to be called or faxed in under my name, address, and birthdate including but not limited to medications, physical therapy, etc.
7. A means for allowing necessary testing including but not limited to bloodwork, radiological tests, etc.
8. To communicate with other healthcare providers in times of emergencies and disasters,etc.

I understand and have been provided with a PATIENT INFORMATION SHEET to read that provides a more complete description of information uses and disclosures. I understand that I have the right to review the PATIENT INFORMATION SHEET prior to signing this consent. I understand that Dr. Grellet and her associates reserve the right to change their notice and practices, but that prior to implementation will inform me so I may read the revised notice before my next appointment.

I understand that Dr. Grellet only uses her directory of patient addresses for her office professional use - that this directory (mailing list) is never sold nor given out for any reason other than for services/prescriptions/insurance billing/etc. for the individual patient as needed.

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, healthcare operations (testing, scheduling of tests or appointments with other providers), and that Dr. Grellet and her associates are not required to agree to the restrictions requested.

I understand that I may revoke this consent in writing, except to the extent that Dr.Grellet has already taken action in reliance thereon.

I further understand and agree that this agreement to release information shall apply to all information accumulated up to this date and to any future information acquired in the future. This agreement to release future information shall remain in force until such time as I shall revoke it in writing.

Information may be released to the following organizations for the indicated purposes:

Laboratories for bloodwork, urine and pap tests
Hospitals and radiology offices for X-rays, mammograms, CAT scans, MRI scans, etc.
Insurance Companies for authorizations, pre-authorizations for necessary tests, medications and billing

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___I request the following restrictions to the USE and DISCLOSURE of my health information:

______________________ ______________________

Signature of Patient or legal representative Date Notice Effective

Dr. Grellet _______ accepts _______denies the restrictions imposed on release of information as stated above.

__________________________ Date___________

Signature
Catherine Grellet, MD
Lopa Patel, FNP
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