Susan P. Epner, M.D.

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

I, _____, understand that as part of my health care, Susan P. Epner, M.D. 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 source 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 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:

- 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.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Susan P. Epner, M.D. 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 taken action in reliance thereon. 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 Susan P. Epner, M.D. reserves the right to change her Notice of Information Practices and prior to implementation, in accordance with Section 164.506 of the Code of Federal Regulations, she will send a copy to the address I have provided.

I wish to have the following restrictions to the Use and Disclosure of my Health Information:

_____

_____

I understand that as a part of this organization's treatment, payment, or healthcare operations it may be 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's Signature Date

FOR OFFICE USE ONLY

☐ Consent received by _____ on _____.

☐ Consent refused by patient and treatment refused as permitted.

☐ Consent added to the patient's medical record on _____.