University Rehabilitation/James Corwin
New Patient Consent to the Use and Disclosure of Health Information
For Treatment, Payment, or Healthcare Operations

I, _____, Social Security Number _____
understand that as part of my health care, **University Rehabilitation/James Corwin** 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 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, and
- 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, and
- 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 **University Rehabilitation/James Corwin** 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 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 **University Rehabilitation/James Corwin** reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should **University Rehabilitation/James Corwin** change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

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

_____

_____

I elect the following person(s) listed below as my **Personal** Health Care Confidant(s). I give permission to University Rehabilitation/James Corwin and its staff to release any and all information regarding my medical treatment to my elected Health Care Confidant(s). I understand that should I choose to change or remove an elected Health Care Confidant, I must do so in writing in the presence of a staff member of University Rehabilitation/James Corwin
or by sending my notarized request in the mail.

Elected Person:	Relationship:
_____	_____
_____	_____
_____	_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

_____ _____
Patient's Signature Patient's Printed Name

_____ _____
Witness Signature Witness Printed Name

_____
Date Signed

NOTARY: (Required if document is not signed in the presence of a staff member).

_____
Notary Signature & Printed Name Date
Place your notary seal below