The Centre for Reproductive Medicine, P.A.
Janelle Dorsett, M.D.

Consent for Use and Disclosure of Protected Health Information (PHI) for Treatment, Payment, or Health Care Operations

I understand that as part of my health care, the Physician originates and maintains records describing my health history, symptoms, examinations and test results, diagnosis, treatment, financial and demographic information, as well as any plans for future care or treatment. The Physician also originates and maintains billing records. I understand and consent to this information being used or disclosed for the following purposes:

- Planning my care and treatment;
- Communications between the Physician and healthcare professionals that act under the direction of the Physician and participating, evaluation, or treatment;
- Collection of fees for medical services;
- Determining liability for payment and obtaining reimbursement;
- Conducting health-care operations, including: the evaluation of health-care services, appropriateness and quality of health-care treatment, and the qualifications of health-care practitioners.

I have been provided with a copy of *Physician's Notice of Privacy Practices* that provides information about how Physician uses and discloses PHI about me. I understand that I have the following rights and privileges:

- The right to review notice prior to signing this consent 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. The Physician is not required to agree to the requested restrictions, but is bound to any restrictions agreed to.

I understand that as provided in the *Notice of Privacy Practices*, the terms of the *Notice* may change. If they do, I may obtain a revised copy from the privacy officer by calling (806) 788-1212.

I understand that I may revoke this consent in writing, except to the extent that the Physician has already taken action in reliance thereon. I also understand that by refusing to sign or revoking this consent, the Physician may refuse to treat me. **I wish to restrict the use or disclosure of my health care as follows:**

_____

_____

I understand that my confidential information may be released to the following individuals:

(1.) _____

(2.) _____

(3.) _____

_____ _____
Signature of Patient or Representative Date

_____ _____
Printed Patient or Representative Name (Relationship) S.S. #

Restriction to use and disclosure of health information:
_____ Accepted _____ Declined

_____
Signature of Employee Date