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

Maintenance of records

I understand that as part of my health care, Southampton Osteopathy LLC originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

* A basis for planning care and treatment
* A means of communication among the 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 the services billed are actually provided.
* A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

Use and Disclosure of Records

I understand and have been provided with a notice 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 payment or health care operations.

I authorize payment of medical benefits to Dr. Stephen Braun for services rendered.
I am aware that Dr. Stephen Braun does not accept Medicaid and its products.
I understand that as part of this organization's treatment, 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.

This consent allows my protected health information to be disclosed only to the business associates of this office, as in your insurance carrier or any laboratory if blood work or testing is necessary. Any other disclosure, to any entity, will require further consent.

I fully understand and accept the terms of this consent.

Patient's Signature _____ Date _____

FOR OFFICE USE
( ) Consent received_____ on _____added to medical record____