



## Consent to the Use and Disclosure of Protected Health Information

Patient Name	Birth Date	MCC #	SSN#

Thank you for choosing Medical Center Clinic (MCC) for your healthcare needs. In order for MCC to provide treatment, obtain payment and/or provide services included in routine health care operations, we may need to use and disclose your health information.

Your Health Information may be used to provide you with medical treatment and services. Also, we may disclose information about you to individuals, entities, and member health professionals that are involved in your treatment and diagnosis or who may need the information to coordinate or manage your care.

We may use or disclose information about you to bill & receive payment for services & treatment provided to you. These disclosures include verification & release of information to your health plan to obtain prior approval to determine whether your plan will cover treatment and/or to individuals and entities involved in collecting amounts owed to us including third party payers.

We may use and disclose information about you when necessary to operate our Clinic and to provide quality care to our patients which may include quality assessments, improving activities and evaluating physician and other personnel qualifications, competence, and conducting general business and administrative activities.

I further agree and acknowledge that:

- Health Information about me is stored in and Electronic Medical Record (EMR)
- If I am a patient of Primary Care Inc., PPCI may access information about me for purpose of treatment, payment, and health care operations.
- I give consent that the information about me that is used and disclosed may contain alcohol, drug abuse, psychiatric (mental health), HIV testing, HIV results, AIDS or generic information.
- I understand that I have the right to request that you restrict how information about me is used or disclosed for treatment, payment, or healthcare operations. I understand that you are not required to agree to these restrictions, but if you do, you are bound by the restrictions.

I, the undersigned, have read the above and give my consent to you, Medical Center Clinic, to use and disclose information about me for the purpose described in this form. I understand that I may revoke this consent, in writing, at any time except where you have already used or disclosed information in reliance on my prior consent.

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Signature of Patient/Parent/Guardian

Relationship to Patient