REGIONAL ORTHOPEDIC Professional Association
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REGIONAL RENEW
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Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by **Regional Orthopedic, PA** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills (i.e. my health plan or attorney) or to conduct health care operations of **Regional Orthopedic, PA.**

I understand that diagnosis or treatment of me by **Regional Orthopedic, PA** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. **Regional Orthopedic, PA** is not required to agree that I may request. However, if **Regional Orthopedic, PA** agrees to a restriction that I request, the restriction is binding on **Regional Orthopedic, PA.**

I have the right to revoke this consent, in writing, at any time, except to the extent that Regional Orthopedic, PA has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and crated or received by my physician, another health care provider, a health plan, my employer of health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is reasonable basis to believe the information may identify me.

I understand I have a right to review **Regional Orthopedic, PA's** Notice of Privacy Practices prior to signing this document.

The **Regional Orthopedic, PA's** Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the **Regional Orthopedic, PA.**

The Notice of Privacy Practices for **Regional Orthopedic, PA** is also provided in the reception area.

This Notice of Privacy Practices also describes my rights and duties of **Regional Orthopedic, PA** with respect to my protected health information.

Regional Orthopedic, PA reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____
Signature of Patient or Personal Representative

_____ _____
Name of Patient or Personal Representative Description of Personal Representative's Authority

_____
Date