

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

Prior to using or disclosing your protected health information to carry out treatment, payment or health care operations, we are required under federal law to obtain your consent.

I consent to **Greystone Family Care** using or disclosing my protected health information for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that if I fail to sign this consent, the physicians and **Greystone Family Care** may refuse to provide care or treatment to me.

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. **Greystone Family Care** is not required to agree to these restrictions. However, if **Greystone Family Care** agrees to a restriction that I request, the restriction is binding on **Greystone Family Care** and the physicians of **Greystone Family Care**.

I have the right to revoke this consent, in writing, at any time, except to the extent that **Greystone Family Care** or the physicians of **Greystone Family Care** has taken action in reliance on this consent.

I understand I have the right to review **Greystone Family Care's** Notice of Privacy Practices prior to signing this consent form. The Notice of Privacy Practices gives a more complete description of the permissible uses and disclosures of my protected health information. The Notice of Privacy Practices for **Greystone Family Care** is also provided in the waiting room for my review.

Greystone Family Care 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 asking for one at the time of my next appointment.

I hereby certify that I have read the provisions set forth in this consent. I understand and agree to the terms of this consent.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority