Patient Name: _____ DOB: _____

Individual Consent to the Use and Disclosure of Individually Identifiable Health Information for Treatment, Payment, and/or Health Care Operations

I understand that as a part of my health care, NorthWest Ohio Primary Care Physicians, Inc. receives, originates, maintains, discloses, and uses individually identifiable health information, including, but not limited to, health records and other health information describing my health history, symptoms, examination and test results, diagnoses, treatment, treatment plans, and billing and health insurance information. I understand that NorthWest Ohio Primary Care Physicians, Inc. and its physicians, other health care professionals, and staff may use this information to perform the following tasks:

- **Diagnose my medical/psychiatric/psychological condition.**
- **Plan my care and treatment.**
- **Communicate with other health professionals concerning my care.**
- **Document services for payment/reimbursement.**
- **Conduct routine health care operations, such as quality assurance (the process of monitoring the necessity for, the appropriateness of, and the quality of care provided) and peer review (the process of monitoring the effectiveness of health care personnel).**

I have received a ***Notice of Information Practices*** that fully explains the uses and disclosures that NorthWest Ohio Primary Care Physicians, Inc. will make with respect to my individually identifiable health information. I understand that I have the right to review the *Notice* before signing this consent. NorthWest Ohio Primary Care Physicians, Inc. has afforded me sufficient time to review this *Notice* and has answered any questions that I have to my satisfaction. I also understand that NorthWest Ohio Primary Care Physicians, Inc. cannot use or disclose my individually identifiable health information other than as specified on the *Notice*. I also understand, however, that NorthWest Ohio Primary Care Physicians, Inc. reserves the right to change its notice and the practices detailed therein prospectively (for uses and disclosures occurring after the revision) if it sends a copy of the revised notice to the address that I have provided.

Patient Name: _____ DOB: _____

I understand that I do not have to consent to the use or disclosure of my individually identifiable health information for treatment, payment, and health care operations, but that, if I do not consent, NorthWest Ohio Primary Care Physicians, Inc. may refuse to provide me health care services unless applicable state or federal law requires NorthWest Ohio Primary Care Physicians, Inc. to provide such services.

I understand that I have the right to request restrictions on the use or disclosure of my individually identifiable health information to carry out treatment, payment, or health care operations. I further understand that NorthWest Ohio Primary Care Physicians, Inc. is not required to agree to the requested restriction but that, if it does agree, it must honor the restriction unless I request that it stop doing so or NorthWest Ohio Primary Care Physicians, Inc. notifies me that it is no longer going to honor the request.

I understand that I have the right to request restriction as to the method of communications to me. For example, I might request that all medical bills be mailed to a certain post office box rather than to my home. I further understand that NorthWest Ohio Primary Care Physicians, Inc. must honor this request if the *method of communication* is reasonable.

I understand that I have the right to object to the use and/or disclosure of my individually identifiable health information for facility directories and to family members.

I understand that I may revoke this consent in writing but that the revocation will not be effective to the extent that NorthWest Ohio Primary Care Physicians, Inc. has already taken action in reliance on my earlier effective consent.

_____ _____

Signature of Patient or Legal Representative Signature of Witness

_____

Printed Name of Patient

Date _____