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

I, __________________________, understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals that 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 services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand there is a more complete description of information uses and disclosures kept on file at Achieve Health. I understand that I have the right to review that notice prior to signing this consent. I understand that Achieve Health reserves the right to change its notice and practices and, prior to implementation, may make available those changes for my review. I understand I have a right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that Achieve Health **is not** required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that Achieve Health has already taken action in reliance thereon.

I wish to have the following restrictions placed on my healthcare information:

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The phone number and or email listed below are the only places my personal health information may be left on voicemail and or electronic email. This includes test results, appointment times or other personal health information. If my phone number changes, I give permission to use my new number without amending this agreement.

Information	Location (circle one)
____	Home/ Work/Mobile
____	Home/ Work/Mobile
____	Electronic Portal
____	Email

I fully understand and accept the terms of this consent form.

_______________________________________   ______________________

Client/Guardian signature   Date

This form will require a signature in the presence of a Achieve Health Employee and will remain in the patient's permanent record until revoked in writing by the signee.