HIPAA CONSENT FORM

Name

Date

New Patient consent to the Use and Disclosure of Protected Health Information for the Treatment, Payment, or Health Care Operations for

TERRY L MCCASKILL MD

I, _____ understand that as part of my health care, Terry L McCaskill MD originates and maintains paper and or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. Furthermore, I understand that Terry L McCaskill MD will access any available electronic prescription history and will submit whenever possible, any prescriptions electronically through a secure website. I understand that this information and activity serves as:

- 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.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.
- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.

I understand and have been provided with a NOTICE OF INFORMATION PRACTICES that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

By signing this form, I am confirming my authorization for use/disclosure of my protected health information as described in the NOTICE OF PRIVACY PRACTICE. I understand that signing this form is not a condition of treatment. I am confirming that I have read the NOTICE OF PRIVACY PRACTICE and agree with all statements contained within.

I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or

revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Terry L McCaskill MD reserve the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Terry L McCaskill MD change their notice, it will be posted to the website www.drmccaskill.com.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand the terms of this consent and I choose to accept or decline these terms:

◯ Accept ◯ Decline

Date

Signature

Submit