

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

PRAIRIESTAR HEALTH CENTER
1600 N Lorraine St
Hutchinson, KS 67501

CONSENT: I consent to the use and disclosure of my protected health information for treatment, payment and healthcare operations. I understand that this consent is voluntary. I understand that I may refuse to sign this consent but that treatment may be denied if I do not sign this consent.

- I understand that the *Notice of Privacy Practices* which provides a more complete description of information on uses and disclosures has been made available to me and presented to me. I understand that I have the right to review the *Notice of Privacy Practices* prior to signing this consent.
- I understand that PSHC reserves the right to change its notice and privacy practices. I can obtain any revised or updated notice by contacting PSHC's contact person listed on the *Notice*.
- I understand I have the right to object to the use of my health information for directory purposes.
- I understand I have the right to request restrictions as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations and that PSHC is not required to agree to any requested restrictions. I understand if PSHC agrees to a restriction it will be binding on PSHC. I understand no requested restriction is binding on PSHC until I receive written notice from PSHC that it has agreed to the restriction. I also understand that only PSHC's Privacy Official has the authority to agree to such requested restrictions. I may also request accommodation of how I receive my protected health information.
- I understand I may revoke this consent but must do so in writing and send it to PSHC's contact person listed in the *Notice of Privacy Practices*, but if I do it won't have any effect on any actions PSHC took before it received the revocation. A written revocation is only effective when actually received. I understand that PSHC may continue to rely on this consent to collect payment for treatment already provided on reliance of this consent even after I have effectively revoked this consent. **This consent shall continue to be valid for any and all treatment, payment and healthcare operations until revoked.**

Patient's Name (please print full name) Patient's Date of Birth

Signature of patient or patient's representative Relationship to patient

Printed name of representative Date Signed