ANDREWS INTERNAL MEDICINE, PA

NEW PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR THE TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS.

I _____, understand that as part of my health care, Andrews Internal Medicine maintains paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnosis, treatment, and any health plans for future care or treatment. This record is also used as a source for applying coding information for my account.

I 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 document.
- The right to restrict the use of my health information regarding any disclosure to carry out treatment, payment, or other health care operations.

I understand that Andrews Internal Medicine is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing. I also understand that by refusing to sign this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations. Should Andrews Internal Medicine change their notice, they will notify me accordingly by an updated notice when I revisit the office.

I fully understand and accept the terms of this consent.

_____ _____

Patient/Parent/Guardian/POA Signature Date