ANDREWS INTERNAL MEDICINE

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

I,_____, understand that a part of my health care, Andrews Internal Medicine maintains paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any 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 or revoking 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.

In my absence, I authorize Andrews Internal Medicine to discuss my health information or account information with: (list names of spouse, children (over the age 18), friends, relatives,etc.) Your information cannot be discussed with anyone Not on this list.

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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 other physicians, laboratories, insurance companies, or other entities, in regards to my medical care and collection of payment for services rendered. I consent to such disclosure for these permitted uses, including disclosures via fax. I authorize Andrews Internal Medicine to leave messages that will identify the caller and the office they are calling from on an answering machine that I provided. Please note that medical information will not be left on the machine. In your absence, a message will be left to call the office back to obtain this information.

I fully understand and accept the terms of this consent.

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Patient/Parent/Guardian/POA Signature Date