ASEDA
Medical Center

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CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

The patient hereby consents to the use or disclosure of his/her individually identifiable health information ("protected health information") and patient medical record information by Aseda Medical Center (the "Practice") in order to carry out treatment, payment or health care operations. The patient should review the practice's *Notice of Privacy Practices* for a more complete description of the potential uses and disclosures of such information. The patient has the right to review such notice prior to signing this consent form.

Aseda Medical Center reserves the right to change the terms of its *Notice of Privacy Practices* at any time. If the Primary Care At Home does change the terms of its *Notice of Privacy Practices*, the patient may obtain a copy of the revised notice.

The patient retains the right to further restricts of how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. Aseda Medical Center is not required to agree to such requested restrictions; however, if Aseda Medical Center does agree to the patient's requested restriction(s), such restrictions are then binding.

The patient acknowledges and agrees that Aseda Medical Center may disclose the patient's protected health information and medical record information to the following individuals who are either the patient's family members, legal representatives, guardian, health care surrogates, or have power of attorney on behalf of the patient.
(**patient must fill out**)

Name/Relationship _____

The patient agrees that Aseda Medical Center may disclose the following types of information contained in the patient's medical records (**please initial, do not check the appropriate categories listed below**):

Restrictions:
_____ HIV/AIDS information
_____ Substance abuse information
_____ If patient is under the age of eighteen (18) Pregnancy information

Restrictions:
_____ Mental Health information
_____ Sexually transmitted disease information

The patient agrees and consents to Aseda Medical Center information in the following alternative manners (**please initial, do not check**, the appropriate categories listed below):

_____ Via email to the patient's designated email address which is _____
_____ Via regular mail with envelopes being marked personal and confidential and address to the patient.
_____ Via telephone, if the patient contacts Aseda Medical Center and provides the appropriate information (including the patient's name, social security number and date of birth).

At all times, the patient retains the right to revoke this consent. Such revocation should be submitted to Aseda Medical Center in writing. The revocation shall be effective except to the extent that Aseda Medical Center has already taken action in reliance to the consent. If you revoke this consent, Aseda Medical Center will only continue to treat you on an emergency basis, and in that case for 30 days.

Aseda Medical Center may refuse to treat the patient if he/she (or an authorized representative) signs this consent and then revokes it, Aseda Medical Center has the right to refuse to provide further treatment to the patient at the time of revocation (except to the extent that Primary Care At Home is required by law to treat individuals).

Patient's name _____ DOB _____

Signature _____ Date _____