HIPAA Patient Communication

Consent for Use & Disclosure of Confidential Health Information

Patient Name:_____ Today's Date:____/____/____

Date of Birth:____/____/____ Medical Record Number:_____

As part of your health care, OMS maintains records describing health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. By signing this form, you are consenting to OMS's use and disclosure of your protected health information to carry out treatment, payment, or health care operations. For a more complete description of such uses and disclosures, please refer to our Notice of Privacy Practices.

If you do not agree to sign this form, OMS may refuse to treat you.

You have the right to review our Notice of Privacy Practices prior to signing this consent. However, we reserve the right to change our privacy practices and change the terms of the Notice. Any new Notice provisions will be effective for all protected health information that we maintain. Should you wish to obtain a revised Notice, you may call our office and ask to speak to our Privacy Officer.

You have the right to request that OMS restrict how we use and disclose your protected health information. We are not required to agree to such restrictions, but if we do, the restriction will be binding on us. If we do agree, we will restrict our use and disclosure to the extent we document such in writing and notify you of same.

You have the right to revoke this consent in writing at any time, except to the extent that OMS has acted in reliance on it.

I understand and agree to the information above:

X_____ ____/____/____

Signature of patient or legal representative of the patient — Date

_____

If legal representative, state relationship to patient

_____

Printed Name