

Consent to use and disclose your health information

This form is an agreement between you, _____ and Susan Eby, NP. When we use the word “you” below, it will also mean your child, relative, or other person if you have written his/her name here:_____.

When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information about you. We use this information to decide what treatment is best for you and to provide your treatment; or if it is necessary to arrange payment for treatment or for other business or government functions.

By signing this form you are agreeing to let us use your information here and send to others for insurance and billing purposes. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information.

If you are concerned about some of your information, you have the right to ask us not to use or share some of your information for treatment, payment, or administrative purposes. You will need to inform us in writing.

After you have signed this consent, you have the right to revoke it (in writing) and we will comply with your wishes about using or sharing your information from that time forward.

I certify that the insurance information I provided is correct. I authorize the release of any medical information necessary to process this insurance claim. Additionally, I request payment of medical benefits to the provider for services rendered to the patient named below.

Signature of patient (or guardian)

Date

Printed name of patient (or guardian)

Relationship to patient

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