Consent To Use and Disclose Protected Health Information For Treatment, Payment and Health Care Operations

Olean Medical Group LLP

Section A:

Patient Name: _____ Patient ID Number: _____

I consent to the use and disclosure of my Protected Health Information by Olean Medical Group LLP ("Olean Medical Group") and by Olean Medical Group's health care professionals, workforce members and vendors providing services or supplies to me for purposes of treatment, payment and health care operations.

I understand that my signature on the consent is required in order for me to receive care from providers of the Olean Medical Group. I further understand that the Olean Medical Group may condition my treatment on obtaining my Protected Health Information for treatment, payment and health care operations.

Section B: Important Information Regarding this Consent:

1. I understand federal and state laws require my consent before Olean Medical Group may use or disclose my Protected Health Information for treatment, payment or health care operations.
2. Understand that this information may be used or disclosed by Olean Medical Group to:
   - diagnose or provide for my care and treatment;
   - communicate among various health care professionals who are involved in my care and treatment;
   - obtain payment for my health care or for the payment activities of another health care provider or entity;
   - provide information to my health insurance company or plan;
   - obtain payment from my health insurance company or plan;
   - assess and review the quality of my care; and
   - conduct its health care operations.
3. I understand I have the right to request a restriction as to how my protected health information is used or disclosed by Olean Medical Group to carry out treatment, payment or health care operations. Olean Medical Group is not required to agree to the restrictions that I may request. However, if Olean Medical Group agrees to a restriction that I request, the restriction is binding on Olean Medical Group.
4. I understand that further information on Olean Medical Group's uses and disclosures of my Protected Health Information for treatment, payment and health care operations is included in Olean Medical Group's Notice of Privacy Practices.

SIGNATURE

I have read and understand the terms of this consent. I have had an opportunity to ask questions about the use or disclosure of my Protected Health Information.

Signature of Patient or Personal Representative: _____

Print Name of Patient or Personal Representative: _____

Description of Personal Representative's Authority: _____

Date: _____

CONTACT INFORMATION

Contact information of the personal representative who signed this form:

Address _____

_____

_____

Telephone: _____ (Daytime) _____ (Evening)

For Olean Medical Group's Use Only

Date Olean Medical Group Obtained Consent: _____

Name and Title of Person Obtaining Consent: _____

Action Taken by Olean Medical Group on Consent: _____

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