Rehabilitation Associates of Naples

*Comprehensive Rehabilitation Services...to help meet life's challenges*

# New Patient Consent

To the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

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I,_____, understand that as part of my health care, Rehabilitation Associates of Naples originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which third party payers can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand that as part of this organization's treatment, payment or health care operations, it may become necessary to disclose by protected health information to another entity, and **I consent to such disclosure for this permitted use, including disclosures via fax.** I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

☐ **I understand that I have been provided with the opportunity to review the Notice of Privacy Policy for Rehabilitation Associates of Naples**. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

I understand that Rehabilitation Associates of Naples is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. 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.

I further understand that Rehabilitation Associates of Naples reserves the right to change their notice and practices, in accordance with Section 164.520 of the Code of Federal regulations. Should Rehabilitation Associates of Naples change their notice, they will send a copy of any revised notice to the address I have provided (whether US Mail, or if I agree, email).

**I wish to have the following restrictions to the use or disclosure of my health information:**

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I hereby authorize Rehabilitation Associates of Naples to discuss my medical progress and plan of treatment with the following family/friends (other than necessary emergency contact):

Name: _____ Relationship: _____ Name: _____ Relationship: _____

Phone: _____ Pasword: _____ Phone: _____ Password: _____

☐ **I consent to having Rehabilitation Associates of Naples leave a message on my answering machine/voicemail**.

I fully understand and accept the terms of this consent:

_____ _____ _____ _____

Signature of Patient/Responsible Party Date Witness Date

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