Clermont Medical Center
BOARD CERTIFIED FAMILY PHYSICIANS

Name: _____ DOB: _____ Date: _____

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE 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 **Clermont 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, and the Patient has the right to review such Notice prior to signing this Consent Form.

The Practice reserves for itself the right to change the terms of its Notice of Privacy Practices at any time. If the Practice does change the terms of its Notice of Privacy Practices, Patient may obtain a copy of the revised Notice.

Patient retains the right to request that the Practice further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to such requested restrictions; however, if the Practice does agree to Patient's requested restriction(s), such restrictions are then binding on the Practice.

Patient authorizes Clermont Medical Center to share his/her medical records and protected health information with the following person (s), group or entity:

_____ _____ _____ _____
Print Name relation Print Name relation
Contact information: _____ Contact information: _____

In case of emergency please contact: phone #: relation:

The Patient agrees that the Practice may **NOT DISCLOSE** the following types of information contained in the Patient's medical records (**PLEASE INITIAL** below the appropriate categories you **DO NOT** want us to disclose.):

_____ HIV/AIDS Information

_____ Mental Health Information

_____ Substance Abuse Information

_____ Sexually Transmitted Disease Information

_____ If Patient is under the age of eighteen (18), Pregnancy Information

Patient agrees and consents to the Practice releasing information to Patient in the following alternative manner (**PLEASE INITIAL** in the appropriate space below):

_____ Via e-mail to the Patient's portal address (please ask for the Portal Agreement form)

I hereby give consent to Clermont Medical Center to provide treatment to the patient. I certify that the information I furnish is true and correct. I know it is a crime to fill out this form with facts that I know are false or to leave out facts I know are important.

I hereby authorize Clermont Medical Center to submit a claim to my insurance carrier or its intermediaries, for all covered services rendered by the physician(s) and authorize and direct my insurance carrier or its intermediaries to issue payment check(s) direct to the physician(s) rendering the covered services for the next 12 months. I hereby authorize Clermont Medical Center to furnish complete information requested by my insurance carrier or its intermediaries regarding services rendered. I further agree that I am responsible for paying my balances which remain after insurance payments have been made, including any cost of collection or legal fee incurred to collect these balances.

Medicare/Medigap authorization: I request that payment of authorized Medicare/Medigap benefits be made either to me or on my behalf to Clermont Medical Center for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to the Practice in writing. The revocation shall be effective *except* to the extent that the Practice has already taken action in reliance on the Consent.

The Practice may refuse to treat Patient if he/she (or an authorized representative) does not sign this Consent Form. If Patient (or authorized representative) signs this Consent and then revokes it, the Practice has the right to refuse to provide further treatment to Patient as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I HAVE RECEIVED A COPY OF THIS CONSENT, AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

Date: _____ Time _____ AM/PM

_____

Signature of Patient (or Authorized Representative*)

_____

Please Print Name

*Please explain Representative's Relationship to Patient and include a description of Representative's Authority to act on behalf of the Patient: _____