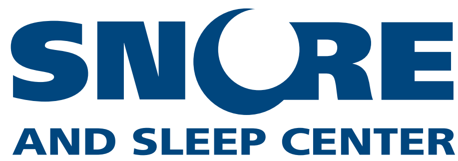

New Patient to the Use and Disclosure of Health Information
for Treatment, Payment, or Healthcare Operations

I, ________________________ understand that as part of my health care, Pulmonary Consultants of San Antonio/Lone Star Sleep Lab, originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care of treatment. I understand that this information serves as:

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

I understand and have seen posted the Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

1. The right to review the notice prior to signing this consent,
2. The right to request restrictions as to how my health information may be used to disclosed to carry out treatment payment, or health care operations.

I understand that Pulmonary Consultants of San Antonio/Lone Star Sleep Lab 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 164.520 of the Code of Federal Regulations.

I further understand that Pulmonary Consultants of San Antonio/Lone Star Sleep Lab, reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations.

I request the following restrictions:____
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I understand that as part of this organization's treatment, payment, or health care operations it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I further understand that as part of this organization' s treatment, payment, or health care operations it may become necessary to request protected health information from another entity and I consent to such disclosure for these permitted uses, including via fax.

I fully understand the terms of this consent.

______________________________ ______________________________
Patient's Signature Date of Birth

______________________________ ______________________________
Social Security # Date

FOR OFFICE USE ONLY
[ ] Consent received by ______________________________ on ________________________
[ ] Consent refused by patient, and treatment refused as permitted
[ ] Consent added to the patient's medical record on