

**ARISTACARE AT WHITING
CONSENT TO USE/DISCLOSE HEALTH INFORMATION FORM**

Although AristaCare at Whiting is not required by law to obtain a signed consent from you for treatment, payment, or healthcare operation purposes, we encourage you to sign this consent so that you are aware of our concern and practices regarding protection of your personal health information.

Should you desire a more complete description of the permissible uses and disclosures of your protected health information, you have the right to review a Notice of Privacy Practices (the "Notice") prior to signing this consent.

The Notice is available by contacting the Administrator. Please note that AristaCare at Whiting reserves the right to change the practices described in the Notice. Should you wish to obtain a revised Notice, please contact the Administrator.

By signing this consent, you agree that AristaCare at Whiting restrict how your protected health information is used or disclosed to carry out treatment, payment, or healthcare operations.

You have the right to request that AristaCare at Whiting restrict how your protected health information is used or disclosed to carry out treatment, payment, or healthcare operations. However, AristaCare at Whiting is not required to agree to such restrictions. If AristaCare at Whiting does agree to a restriction that you request, such restriction will be binding.

You have the right to revoke this consent in writing, except to the extent that AristaCare at Whiting has taken action in reliance on your consent.

Acknowledgement and Agreement:

I consent to AristaCare at Whiting sending protected health information to the insured in the event that I am receiving treatment but am not the insured under my insurance policy. Such information may include, but not be limited to, explanation of benefits ("EOB") or invoices regarding my treatment. I understand that if I do not want such protected health information mailed to the insured, then I will notify AristaCare at Whiting of my objection and will complete a Request for Restriction of Use and Disclosure Form.

I consent to AristaCare at Whiting releasing my religious clergy.

I consent to AristaCare at Whiting releasing my protected health information to the following individuals:

Name Relationship to Patient

Name Relationship to Patient

I have received a copy of AristaCare at Whiting's Notice of Privacy Practices.

I hereby certify that I have read the provisions set forth in this consent. I understand and agree to the terms of this consent.

Print Patient's Name AristaCare at Whiting Universal ID #

Signature of Patient or Representative Date

Name of Personal Representative (if applicable) Relationship to Patient