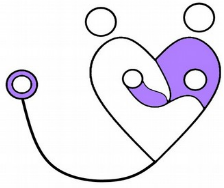

Cheryl Newman M.D.
Family Medicine

Consent to Use and Disclose Protected Health Information for Treatment, Payment and Health Care Operations

2550 Baird Road
Penfield, NY 14526
585-395-1111
585-395-1116 (fax)
www.cherylnewmanmd.com

Name (please print):_______________________________________ Date of Birth:_________

I authorize the use and disclosure of my Protected Health Information by Cheryl Newman M.D. and by her staff for the purposes of treatment, payment and health care operations.

Important Information Regarding this Consent:

1. I understand New York laws require my consent before the office may use or disclose my Protected Health Information for treatment, payment or health care operations.

2. I understand that this information may be used or disclosed by the office to:
   - Plan my care and treatment;
   - Communicate among various health care professionals who are involved in my care or treatment;
   - Obtain payment for care provided by the facility 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; and
   - Assess and review the quality of my care.

3. I understand that my signature on the consent is required in order for me to receive care from the office, and that the office may condition my treatment on obtaining my consent for use and disclosure of my Protected Health Information for treatment, payment and health care operations.

4. I understand that further information on the office's uses and disclosures of my Protected Health Information for treatment, payment and health care operations is included in the office's Privacy Practices. I understand that the complete Privacy Practices notice is on file at the office and is available to me upon request.

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. This authorization will continue until otherwise indicated in writing.

Signature:____ Date:_________________

If signed by Authorized Representative, please complete the following:

Print name of Authorized Representative:____

Description of Authorized Representative's Authority:_______________________________________