

**ARTHRITIS CONSULTANTS OF TIDEWATER**  
**Consent to the Use and Disclosure of Health Information**  
**for Treatment, Payment, or Healthcare Operations**

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

I understand that as part of my healthcare, this organization originates and maintains health 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 evaluation information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization 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.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Notice Effective Date or Version

Additionally, your healthcare provider may require an accurate listing of current or recent medications you have used which may not necessarily be related to the condition you are seeing the doctors of Arthritis Consultants. This information may additionally be collected electronically through **SureScripts** or through the Virginia Department of Health Prescription Monitoring Program. By initialing below, you are giving consent for your provider to request this information electronically.

**I grant the Arthritis Consultant providers consent to request a prescription report which may include controlled substances for up to the past 12 months electronically:**

Initials