

CONSENT FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I, _____, understand that as part of my healthcare, Martin Berry M.D. Inc. 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 all employees of Martin Berry M.D. Inc. have received training and will protect my health information within HIPAA guidelines. 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.
- By refusing to sign this consent, Martin Berry M.D. Inc. has the right to refuse treatment
- I have the right to request restrictions as to how my health information may be used or disclosed and that Martin Berry M.D. Inc. is not required to agree to the requested restrictions.
- I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I wish to have the following restrictions to the use or disclosure of my health information:

I fully understand and accept/ decline the terms of this consent.

Signature _____

Date _____