

PREMIER INTERNISTS

Division of Millennium Medical Group

Patient Consent to the Use and Disclosure of Health Information for treatment, payment or healthcare operations

I, _____, understand that as a part of my health care, Millennium Medical Group, P.C. originates maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of 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 surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I acknowledge that a copy of Millennium Medical Group, P.C. Notice of Privacy Practices was posted in a clear and prominent place where I was able to read the Notice of Private Practices. I know that I could request a copy and take it with me. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how many health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Millennium Medical Group, P.C. 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, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I understand that Millennium Medical Group, P.C. reserves the right to change its notice and practices, in accordance with Section 164.520 of the Code of Federal Regulation. Should Millennium Medical Group, P.C. change its notice, it will post a new revised notice and provide a copy of any revised notice to me upon my request.

I wish to have the following restriction with regard to the use or disclosure of my health information:

I understand that as a 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 fully understand and accept the terms of this consent.

Patient Signature _____ Date _____

The following applies only if a restriction is added by patient:

Practice Name: Michigan Premier Internists, a division of Millennium Medical Group, P.C.

Accepts Restriction:

Privacy Officer _____ Date _____

Does not Accept Restriction:

Privacy Officer _____ Date _____

For office use only:

___ Consent received by _____ on _____

___ Consent refused by patient, and treatment refused as permitted.

___ Consent card added to the patient's medical record on _____