South Hills Physical Therapy Clinic

1639 Oak Street, Eugene, OR 97401 541-686-0101 * 541-686-0202 Fax

CONSENT TO USE OR DISCLOSE MEDICAL INFORMATION

I authorize ***South Hills Physical Therapy Clinic*** to use and disclose the health and medical information of _____ for the purpose of Treatment, Payment, and Health Care Operations.

- Treatment includes activities performed by ***South Hills Physical Therapy Clinic*** providing care to you, coordinating, or managing your care with third parties, and consultations with and between other health care providers involved in your care.

- Payment includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization of management activities which may include review of health care services for medical necessity, justification of charges, and preauthorization.

- Health Care Operations includes the necessary administrative and business functions at our office.

You may review ***South Hills Physical Therapy Clinic's*** Notice of Privacy and Protection Practices for additional information about the uses and disclosures of information described in this consent prior to signing this consent.

Because we reserve the right to change our privacy practices in accordance with the law, the terms contained in the notice may also change. A summary of the Notice will be posted in the office. We will offer you a copy of the Notice on your first visit after the effective date of the then current notice.

As more fully explained in the Notice, you have the right to request restrictions on how I use and disclose your protected health information for treatment, payment and health care operation purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment.

I understand that I have the right to revoke this CONSENT if I do so in writing, except to the extent that ***South Hills Physical Therapy Clinic*** has already used or disclosed the information in reliance on this CONSENT.

Date _____ Patient or Guardian Signature _____