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New Patient Consent to the Use and Disclosure of Health Information for
Treatment, Payment, or Healthcare Operations

I _____ understand that as part of my healthcare, this organization originates and maintains paper and/or electronic records describing my health history, symptoms, examinations, and test results, diagnosis, 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 communicating among the many healthcare 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 the services were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competency of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information issues and disclosures. I understand that I have the following rights and privileges:

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

I understand that this 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. I also understand that by refusing to sign the consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that this organization reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should the organization change their notice, they will send a copy of any revised notice to the address that I have provided (whether U.S mail, or if I agree, e-mail).

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

I understand that as part of this organization's treatment, payment, or healthcare 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 disclosure via fax or e-mail.

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

Patient Signature

Date

Office Use Only

[] Consent received by _____ on _____

[] Consent refused by patient, and treatment refused as permitted

[] Consent added to the patient medical record on _____

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BABROUR ORTHOPAEDIC & SPORTS MEDICINE
GWINNETT ORTHOPAEDIC & SPORTS MEDICINE

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