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

I, _____ understand that as part of my healthcare, Walton Family Medicine, P.C., (WFM) originates and maintains health records describing my health history, symptoms, examinations, test results, diagnoses, treatment, and plans for future care and 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 may 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 agree, by my signature below, that I have received a copy of WFM's "Notice of Privacy Practices for Protected Health Information", which provides a more complete description of information, uses and disclosures, prior to signing this Consent. I understand that WFM may change its "Notice of Privacy Practices for Protected Health Information," from time to time and that notice of such changes will be provided to me upon request.

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. I understand and agree that WFM is not required to agree to any restrictions that I may request, but, if WFM agrees, WFM will be bound by that restriction.

I understand that I may revoke this Consent by notifying WFM in writing that I revoke this Consent unless WFM has used or disclosed my Health Information in reliance on this Consent.

I understand and agree that WFM has the right to disclose relevant Health Information to my family member, other relative, close or personal friend or anyone identified by me.

_____

(Printed Name of Patient or Legal Representative)

_____ _____

(Signature of Patient or Legal Representative) (Date)