**HIPAA Patient Information Consent Form**

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

I understand that as part of my healthcare, the office of Rana K. Munna M.D. 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 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 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 and that Dr. Munna’s Office 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 office of Rana K. Munna M.D. has already taken action in reliance thereon.

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Signature Date

The following people are allowed to receive and discuss my health information and/or pick up medication or prescriptions on my behalf:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_