



Consent to Use OR Disclose Information For Treatment, Payment or Health Care Operations

The patient or legally authorized guardian hereby consents to the use or to disclose use of his/her individually identifiable health information ("protected health information") by Triangle Orthopaedic Associates, P.A. (TOA) in order to carry out treatment, payment or health care operations. The patient should review TOA Notice of Privacy Practices for Protected Health Information (Notice) for a more complete description of the potential uses and disclosures of such information. The patient has the right to review such Notice prior to signing this consent form.

TOA reserves the right to change the terms of its Notice of Privacy Practices for Protected Health Information (Notice) at any time. If TOA does change the terms of its Notice, the patient may obtain a copy of the revised Notice.

Patients retain the right to request that TOA further restrict how his/her protected health information is used or disclosed to carry our treatment, payment, or health care operations. TOA is not required to agree to such requested restrictions; however, if TOA does agree to Patient's requested restriction(s), such restrictions are then binding on TOA.

The patient retains the right to revoke this Consent. At all times such revocation must be submitted to TOA in writing. The revocation shall be effective except to the extent that TOA has already taken action in reliance on the Consent.

TOA may refuse to treat patient if he/she (or an authorized representative) does not sign this Consent Form (except to the extent that TOA is required by law to treat individuals). If patient (or authorized representative) signs this consent form and then revokes Consent, TOA has the right to refuse to provide further treatment to patient as of the time of revocation (except to the extent that TOA is required by law to treat individuals).

I authorize release of my medical information to the following companies or individuals:

Name	Relationship	Telephone number
Name	Relationship	Telephone number
Name	Relationship	Telephone number

Additionally, I consent to treatment necessary for the care of the above named person for whom I am legally responsible. I authorize the release of all medical records to the referring or primary care physicians, or to other physicians as required for treatment and to my health insurance company, if applicable. I authorize transmission of medical information by fax. I authorize my health insurance company to utilize the medical information as reasonably necessary for the proper administration of the health plan. I also acknowledge full financial responsibility for services rendered by TOA.

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

I authorize release of medical information to insurance carriers and authorize insurance payment directly to TOA. I am responsible for all of my co-pay charges and those charges denied or determined non-covered by my insurance.

PATIENT'S SSN _____ PRINTED NAME _____

LEGAL GUARDIAN _____ SIGNATURE & DATE _____