

Consent to Release Personal Health Information

I understand that under the law Heartland Medical Services, P.C., is obligated to keep private my health information and not disclose this information to anyone.

I give Heartland Medical Services, P.C., my consent to disclose my protected health information for treatment, to obtain payment from insurance companies, for health care operations like quality reviews.

I have been informed that I may review Heartland Medical Services, P.C.'s Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that Heartland Medical Services, P.C., has the right to change their privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that Heartland Medical Services, P.C., is not required to agree with the request. If the practice agrees to the requested restriction(s), they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Signature: _____ Date: _____
Patient, Parent, or legal guardian

If signed by patient representative, state relationship to patient: _____