

## **Patient Consent for Use/Disclosure of Health Care Information**

**Patient's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**I understand that the patient's health information is private and confidential. I understand that Meehan Medical works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.**

**I understand that Meehan Medical may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.**

**Meehan Medical has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy. I understand that I have the right to read the "Notice" before signing this agreement.**

**Meehan Medical may update this "Notice of Privacy Practices". If I ask, Meehan Medical will provide me with the most current "Notice of Privacy Practices".**

**Under the terms of this consent, I can ask Meehan Medical to limit how the patient's health information is used or disclosed to carry out treatment, payment or health care operations. I understand that Meehan Medical does not have to agree to my request. If Meehan Medical does agree to my request, I understand that Meehan Medical would follow the agreed limits.**

**I may cancel this consent in writing at any time by doing one of the following:**

- 1) Signing and dating a form that Meehan Medical can give me called "revocation of Consent for Use and Disclosure of Health Care Information": or**
- 2) Writing, signing and dating a letter to Meehan Medical. If I write a letter, it must say that I want to revoke my consent to authorize the use and disclosure of the patient's personal health information for treatment, payment, and health care operations.**

**If I revoke this consent, Meehan Medical does not have to provide any further health care services to the patient.**

**My signature below indicates that I have been given the chance to review a current copy of Meehan Medical's "Notice of Privacy Polices". My signature means that I agree to allow Meehan Medical to use and disclose the patient's personal health information to carry out treatment, payment, and health care operations.**

\_\_\_\_\_  
**Patient or legally authorized individual signature**

\_\_\_\_\_  
**Date**

---

**Relationship to patient if signed by anyone other than the patient (parent, legal guardian, etc.)**