

Consent for Purpose of Treatment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Bluegrass Orthopaedics & Hand Care for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to contact health care operations of Bluegrass Orthopaedics & Hand Care.

I understand that diagnosis or treatment of me by Bluegrass Orthopaedics & Hand Care may be conditioned upon my consent as evidence by signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Bluegrass Orthopaedics & Hand Care is not required to agree to the restrictions that I may request however, if Bluegrass Orthopaedics & Hand Care agrees to a restriction that I request, the restriction is binding on Bluegrass Orthopaedics & Hand Care and any healthcare provider of Bluegrass Orthopaedics & Hand Care.

I have the right to revoke this consent in writing at any time except to the extent that Bluegrass Orthopaedics & Hand Care or any health care provider of Bluegrass Orthopaedics & Hand Care had taken action in reliance on the consent.

My protected health information means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, health plan, my employer or health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to revoke Bluegrass Orthopaedics & Hand Care Notice of Privacy prior to signing this document. Bluegrass Orthopaedics & Hand Care Notice of Privacy Practices has been provided to me.

The Notice of Privacy describes the types of uses and disclosures of my protected information that will occur in my treatment, payment of my bills or in the performance of health care operations of Bluegrass Orthopaedics & Hand Care.

The notice of Privacy Practices for Bluegrass Orthopaedics & Hand Care is also provided in the office where Notice of Privacy Practices is posted and on the Bluegrass Orthopaedics & Hand Care website bluegrassortho.com

The Notice of Privacy Practices also describes my rights and the duties of Bluegrass Orthopaedics & Hand Care with respect to my protected health information. Bluegrass Orthopaedics & Hand Care reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I May obtain a revised notice of privacy practices by accessing the Bluegrass Orthopaedics & Hand Care website, or calling the office and requesting a revised copy to be sent in the mail or asking for one at the time of my next appointment.

I have received the Surgical Division Patient’s Right and Responsibilities, Physician Ownership Information, and the Advanced Directives Policy.

Patient Name: _____ **DOB:** _____ **Acct #** _____

Signature of Patient: _____ **Date:** _____

Signature of Personal Representative if patient is unable _____

Description of Personal Representative: _____ **Witness** _____
(On behalf of BGO)

Description of Personal Representatives Authority

Note:

- **If you are not available when we call may we have permission to leave a message either on your answering machine or with another person? Yes _____ No _____**
- **Please list names of family members or friends that we may discuss your care with and identify their relationship to you:**

<u>Name</u>	<u>Relationship</u>
_____	_____
_____	_____
_____	_____