The Kaufmann Clinic, Inc.

Crawford Long Medical Office Tower, 550 Peachtree St., Suite 1700, Atlanta, GA 30308
2001 Professional Way, Suite 220, Woodstock , GA 30188

CONSENT AGREEMENT

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

I, _____,
(Please Print Name Clearly)

understand that as part of my healthcare, The Kaufmann Clinic, Inc., originates and maintains health records describing my health history, symptoms, examinations 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,
- A tool for routine healthcare operations such as assessing quality.

I understand and have been provided with a **Notice of Privacy for Protected Health Information** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that The Kaufmann Clinic reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. 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 The Kaufmann Clinic is not required to agree to restrictions requested. I understand that I may revoke this consent in writing, except to the extent that The Kaufmann Clinic has already taken action in reliance thereon.

Consent Agreement (continued)

I wish to have the following restrictions to the use or disclosure of my health information:

I fully understand and **accept** the terms of this consent._____

I fully understand and **decline** the terms of this consent_____

Signature of Patient_____Date_____

Or By_____Date_____
(Patient's Representative)