Patient Consent Form

I consent to the use or disclosure of my protected health information (PHI) by Lakeview Healthcare System for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations. I understand that diagnosing or treatment of me by Lakeview Healthcare System may be conditioned upon my consent as evidence by my signature on this document.

I understand I have the right to request a restriction as to how protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Lakeview Healthcare System is not required to agree to the restrictions that I may request, and may request I seek another Internal Medicine physician. However, if Lakeview Healthcare System agrees to a restriction that I may request, the restriction is binding on the physician.

I have the right to revoke this consent, in writing, at any time, except to the extent that Lakeview Healthcare System has taken action in reliance on this consent.

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

I understand I have a right to review Lakeview Healthcare System notice of Privacy Practices prior to signing this document. The Lakeview Healthcare System Center's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of bills, or in the performance of health care operations. This notice of Privacy Practices describes my rights and the Lakeview Healthcare System duties with respect to my protected health information.

Lakeview Healthcare System reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of private practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

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Signature of Patient or Personal Representative Date