Mirasol Physical Rehab Center

Patient Consent Form

I, _____, understand that as part of my health care, the practice of MiraSol Physical Rehab Center originates and maintains paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnoses, treatment and any plans for future care or treatment. I understand 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 and reviewing the competence of healthcare officials.

I understand and have been provided with a Notice of Information Practices that provides a more complex description of information, uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to request restrictions as to how my health information may be used or disclosed to certain treatments, payments, or health care options.

I understand that the practice of MiraSol Physical Rehab Center is not required to agree to the restrictions requested and understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164, 506 of the Code of Federal Regulations.

I further understand that the practice of MiraSol Physical Rehab Center reserves the right to change their notice and practices in accordance with Section 164, 520 of the Code of Federal Regulations. Should the practice of MiraSol Lymphedema & Rehab Center change their notice, they will send any revised notice to the address I have provided below (whether US mail, or if I agree, e-mail).

Address: _____
E-mail: _____

I understand that as part of this organization's treatment, payments, or health care operations, it may become necessary to disclose my protected health information to another entity (i.e. my health insurance, or referring physician) and I consent to such disclosure and permitted use, including disclosures via fax. I understand that if other requests from outside providers request your protected health information, a medical records release form will be requested form our facility before fulfilling that request.

I understand and **accept** or **decline** the terms of this consent.

_____ _____
Patient Signature Date

OFFICE USE ONLY
Consent received by_____ Date_____