EUREKA FAMILY PRACTICE
2675 Harris Street, Eureka CA 95503
707-443-8335 fax 707-443-7327

CONSENT TO USE OR DISCLOSE MEDICAL INFORMATION

I **authorize** Eureka Family Practice to **use and disclose** the health and medical information of _____ for **Treatment, Payment and Health Care Operations**.
(Name of Patient)

- **Treatment**: includes activities performed by a physician, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers my/our practice by telephone as the on-call physician.

- **Payment**: includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims and utilization management activities which may include review of health care services for medical necessity, justification of charges, precertification and preauthorization, billing employer for authorized services. I understand that if I do not allow disclosure for payment that I may be responsible for any applicable charges. **Initials** _____

- **Health Care Operations:** includes the necessary administrative and business functions of our office

You may review Eureka Family Practice ***"Notice of Privacy Practices"*** for additional information about the uses and disclosures of information described in this CONSENT prior to signing this CONSENT. Please verify that you have received a copy of our Notice by ***placing your initials here:*** ____.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the ***Notice*** may change also. A summary of the ***Notice*** will be posted in the lobby of our office and our website indicating the effective date of the ***Notice*** in the upper right hand corner. We will offer you a copy of the ***Notice*** on your first visit to us after the effective date of the current ***Notice***. We will also provide you with a copy of the ***Notice*** upon your request.

As more fully explained in the ***Notice***, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. ***We are not required to agree to your request***. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the **Notice**.

I understand that I have the right to revoke this CONSENT provided that I do so in writing, except to the extent the (name of physician/Physician group) has already used or disclosed the information in reliance on this CONSENT.

I have been offered a copy of Eureka Family Practice's Notice of Privacy Practices, which is also posted and available in the reception area and at eurekafamilypractice.com. I authorize Eureka Family Practice to leave appointment reminders or messages at my home number either on answering machine or with any person who is answering this phone. **Yes**_____**No**_____

If you wish to **authorize a Personal Representative** access to your medical care and discuss medical needs on your behalf please list their name or names below:

Name: _____ Name:_____

_____ _____ **(or)**
(Date) **(Signature of patient)**

_____ _____
(Date) **(Signature of person authorized by law)**