New Patient Consent to the Use and Disclosure of Health Information
For Treatment, Payment, or Healthcare Operations

I, ___________________________, understand that as part of my health care, DSC Health & Wellness Center, originates and maintains paper and/or electronic records describing my health history, symptoms, examination 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 and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Privacy Policies that provides a more complete 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 carry out treatment, payment, or health care operations

I understand that DSC Health & Wellness Center is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except 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 a permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that DSC Health & Wellness Center reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should DSC Health & Wellness Center change their notice, they will give a revised notice to the patient upon the next office visit.

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

__________________________________________________________________________
I agree that the following individual(s) ___________________Relationship(s)___________ may have access to my Protected Health Information, including lab or test results, and diagnosis.

I understand that as part of this organization’s treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept/decline the terms of this consent.

__________________________________________________________________________
Patient’s Signature                                                                 Date

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FOR OFFICE USE ONLY

[   ] Consent received by ____________________________ on ______________________

[   ] Consent refused by patient, and treatment refused as permitted.

[   ] Consent added to the patient’s medical record on ____________________________