

ERIC J. STELNICKI, M.D., P.A.

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 Eric J. Stelnicki M.D., P.A. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and my plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A mean 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, and
- 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 Information Practices* 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 object to use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be uses or disclosed to carry out treatment, payment, or health care operations.

I understand that Eric J. Stelnicki, M.D., P.A., reserves the right to change their notice and practice prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Eric J. Stelnicki M.D., P.A., change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S mail or, if I agree email).

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

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 such disclosure for these permitted uses, including disclosure via fax.

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

Name of Patient or Personal Representative

Description of personal

FOR OFFICIAL USE ONLY

[] Consent received by _____ on _____

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

[] Consent added to the patient's medical record on _____

