TRIANGLE ARTHRITIS & RHEUMATOLOGY ASSOCIATES
CONSENT TO USE OR DISCLOSE MEDICAL INFORMATION

I authorize Triangle Arthritis & Rheumatology Associates to use and disclose the health and medical information of _____ (print your name) For the following purposes:

1) Treatment (includes activities performed by a physician or other health care Provider directly delivering care to you, coordination or managing care provided to you with third parties, and consultations with and between Physicians and other health care providers).
2) **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, including review of health care services for medical necessity, justification of charges, precertification and preauthorization of services.)**
3) Health care operations (includes the necessary administrative and business functions of your health care provider.)
4) Person (s) who you authorize your information to be disclosed to.

_____ _____
Name (s) Phone number

You may review our 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, we will post a copy of the Notice in the lobby of our office, and the Notice will have, in the upper left corner of the first page, the effective date of the Notice. 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.

You have the right to revoke this CONSENT provided that you do so In writing, except t the extent that we have already used or disclosed the information in reliance upon this CONSENT.

_____ _____
Date *Signature of patient*

_____ _____
Date *Signature of person authorized by law*