# Drs. Combs and Lutz, L.L.C.

## CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

**Name:** ______________________________________________ **Date of Birth:** ________________________________

I consent to the use or disclosure of my protected health information by Drs. Combs and Lutz for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Drs. Combs and Lutz.

I understand that diagnosis or treatment of me by Drs. Combs and Lutz may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Drs. Combs and Lutz is not required to agree to the restrictions that I may request. However, if Drs. Combs and Lutz agrees to a restriction that I request, the restriction is binding on Drs. Combs and Lutz.

I have the right to revoke this consent, in writing, at any time, except to the extent that Drs. Combs and Lutz has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Drs. Combs and Lutz's Notice of Privacy Practices prior to signing this document.

Drs. Combs and Lutz's Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Drs. Combs and Lutz.

The Notice of Privacy Practices for Drs. Combs and Lutz is also posted in the waiting room.

This Notice of Privacy Practices also describes my rights and the duties of Drs. Combs and Lutz with respect to my protected health information.

Drs. Combs and Lutz reserves the right to change the privcy practices that are described in the Notice of Privacy Practices.

I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

______________________________________________
Signature of Patient or Personal Representative

______________________________________________
Name of Patient or Personal Representative (PRINT)

______________________________________________
Date

______________________________________________
Description of Personal Representative's Authority