

OAKLAND BONE & JOINT SPECIALISTS

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CONSENT FOR USE AND DISCLOSURE OF PROTECTED INFORMATION

Pursuant to the requirements found in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) the following is offered for your information and consent. Please be aware that it is office policy to require your reading and signing of this form prior to the provision of treatment or any other medical services.

Patient's Name _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examinations and test results, diagnosis, treatment and any plans for future care treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the healthcare 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 care quality and reviewing the competence of healthcare professionals.

I understand that I have a right:

- To object to the use of my health information for care coordination purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations, and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken in.
- Of reliance thereon.

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

If you would like to read more about HIPAA rules and regulations ask the office staff and they can provide more information for you to read.

OFFICE USE ONLY: ___Accepted ___Denied

Signature of Patient or Legal Representative & Date:

Patient Signature: _____ **Date:** _____

_____ Signature of Office Staff, Date