QUINCE ORCHARD
MEDICAL CENTER

Consent for Purposes of Treatment, Payment, and Healthcare Operations

I, _____, (Name of Patient) consent to Quince Orchard Medical Center's ("the Practice's") use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health condition; the provision of health care to me; or the past, present or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees, in writing, to a restriction that I request, the restriction is binding on the Practice.

I acknowledge that I have received, reviewed, understand, and agree to the Notice of Privacy Practices of Quince Orchard Medical Center, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received, or maintained by the Practice.

I have the right to revoke this consent, in writing, at any times, except to the extent that Physician or the Practice has acted in reliance on this consent.

_____ _____

Patient Name Guardian Name

_____ _____

Patient or Guardian's Signature Date