



Family Health Care of Northwest Ohio, Inc.
140 Fox Road Suite 304
Van Wert, OH 45891
Phone: 419-238-6747 Fax: 419-238-3721

**CONSENT TO USE & DISCLOSE HEALTH INFORMATION FOR TREATMENT,
 PAYMENT & HEALTH CARE OPERATIONS**

Patient Name _____ DOB _____ SS# _____

Permission to Use & Disclose Your Health Information. By signing this consent, you authorize us to use and/or disclose your health information for treatment, payment or health care operations. You have the right not to sign this consent. However, if you refuse to sign this consent, we have the right to refuse to treat you.

Right to Review Notice of Privacy Practices. You have the right to review a copy of our Notice of Privacy Practices before signing this consent or after any revisions. Our Notice of Privacy Practices details how we may use and disclose your health information. We may amend the notice from time to time.

Right to Request Restrictions on Use/Disclosure. You have the right to request, in writing, that we restrict how we use and/or disclose your protected health information for the purpose of providing treatment, obtaining payment for our services, and/or conducting health care operations. Please note that we are not required to agree to any restriction you may request. If, however, we decide to agree to a restriction you have requested, we must restrict our use and/or disclosure of your health information in the manner described in your request.

Right to Revoke Consent. You have the right to revoke this consent at any time, in writing. Note that your revocation of this consent will not be effective for disclosures we have already made in reliance on your prior consent. We also have the right to refuse to provide further treatment if you revoke this consent.

Right to Receive a Copy of This Consent Form. You have a right to receive a copy of this consent form after you sign it.

Effective Period. This consent is effective until you revoke it, in writing.

I have read and understand this consent and hereby authorize **Family Health Care** to use and/or disclose my health information for treatment, payment, or health care operations.

Patient's Signature/Representative _____ Date _____

Printed Name of Patient's Representative _____ Relationship _____

I authorize Family Health Care Staff to give the following people information concerning my health care. This includes information about my health care, my appointment times, picking up prescriptions, etc. Only person(s) listed on this form will be able to receive information about me from Family Health Care staff. There will be no exceptions. If "NONE" is listed, no one will receive information about my health care.

Name(s) _____ Relationship to Patient _____

Name(s) _____ Relationship to Patient _____

Patient Signature _____ Date _____

Relationship to Patient (if signed by representative of patient) _____