CONSENT TO USE AND DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATION PURPOSES

Client Name ____ Date of Birth ______________________________
Client Medical Record # _____________________________ Client SS # ____
I give my voluntary consent for ____ to use
(Name of Provider)
and disclose health information regarding ____
(Client Name)
to the following agencies/individuals when applicable for purposes of treatment*, payment** (including benefit payment and for establishment of entitlements) and health care operations***: Social Security Administration, my Social Security Benefit Representative Payee, Civil Service, Medicaid, Medicare, Veterans Administration, Armed Services, State Employee Health Plan, Disability Determination Office, Railroad Retirement, Blue Cross/Blue Shield, any other health or benefit program for determination of coverage and for disclosure of information related to payment activities, this agency's Human Rights Committee, community agencies that may need to provide services to aid in my treatment or payment such as County Dept. of Social Services, Vocational Rehabilitation, Area Agencies on Aging, educational sources (e.g., schools, teachers, counselors), any health care providers my treatment/habilitation team may refer me to or request information from for treatment purposes (e.g., hospitals, clinics, labs, physicians, psychologists, area programs) and any of the following agencies/individuals not listed above:
____
____. I also
consent for you to disclose information relevant to payment activities to the person responsible for payment of my bills (guarantor) if different from myself ____.
(Guarantor Name)
I understand that state and federal laws permit certain uses and disclosures for treatment, payment, and health care operations without my consent and these have been explained in the *Notice of Privacy Practices* that has been provided to me. I understand that the health information used and disclosed may include information such as HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing, if applicable.
I understand this consent is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for payment purposes, wherein the consent is valid until the need for disclosure is satisfied. I understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it, and that I will be asked to sign the *Revocation Section* on the back of this form. I further understand that any action taken on this consent prior to the rescinded date is legal and binding. A copy of this consent shall be considered as valid as the original.

(Signature of Client)	*(Date)*	*(Witness Signature-If Required)*
(Signature of Personal Representative)	*(Date)*	*(Personal Representative Relationship/Authority)*