THE MAXWELL GROUP
CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I understand that as a part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test result, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among other health professionals who contribute to my care
- A source of information for applying my diagnosis and procedural information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that *The Maxwell Group* reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right 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 Maxwell Group* is not required to agree to the restrictions requested. I understand and that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

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Printed Name of Patient **Date of Birth**

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Signature of Patient or Legal Representative **Description of Personal Representatives Authority**

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Date of Signing