

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

I, \_\_\_\_\_, UNDERSTAND THAT AS PART OF MY HEALTHCARE, THIS PRACTICE ORIGINATES AND MAINTAINS HEALTH RECORDS DESCRIBING MY HEALTH HISTORY, SYMPTOMS, EXAMINATION AND TEST RESULTS, DIAGNOSIS, 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 THE MANY HEALTH 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 ACCURATELY PROVIDED
- A TOOL FOR ROUTINE HEALTHCARE OPERATIONS SUCH AS ASSESSING QUALITY AND REVIEWING THE COMPETENCE OF HEALTHCARE PROFESSIONALS

I UNDERSTAND THAT NEW BRAUNFELS ORTHOPAEDIC SURGERY & SPORTS MEDICINE RESERVES THE RIGHT TO CHANGE NOTICES AND PRACTICES. I UNDERSTAND THAT I HAVE THE RIGHT TO OBJECT TO THE USE OF MY HEALTH INFORMATION FOR DIRECTORY PURPOSES. 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 NEW BRAUNFELS ORTHOPAEDIC SURGERY & SPORTS MEDICINE IS NOT REQUIRED TO AGREE TO THE RESTRICTIONS REQUESTED. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT IN WRITING, EXCEPT TO THE EXTENT THAT THE ORGANIZATION HAS ALREADY TAKEN ACTION IN RELIANCE THEREON.

I WISH TO HAVE THE FOLLOWING RESTRICTIONS TO THE USE OR DISCLOSURE OF MY HEALTH INFORMATION:

I FULLY UNDERSTAND AND ACCEPT/DECLINE THE TERMS OF THIS CONSENT.

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

This office has a Physician Assistant as part of our treatment team. This letter is to inform you of his possible participation in your care. A Physician Assistant is a graduate of a certified training program and is licensed by the state board. Under the supervision of a physician, a physician assistant can diagnose, treat monitor common acute and chronic diseases as well as provide health maintenance care. Supervision does not require the constant physical presence of the supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided.

A physician assistant may provide such medical services that are within his/hers education, training and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/ or performing diagnostic and therapeutic procedures
- Formulating a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Assisting at surgery
- Offering counseling and education
- Supplying sample medications and writing prescriptions (allowed by law)
- Making appropriate referrals

I have read the above, and understand that the services of a Physician Assistant may be utilized for my health care needs.

I understand that at any time I can request to see the physician.

Name:	Date
Signature	Witness: (optional)