

DR. JEFF JOHNSON, MD PA
DR. LAUREN ASH
General and Laparoscopic Surgery

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, 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 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 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 Privacy 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 organization 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 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 the organization 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 take action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

Signature of Patient or Guardian

Date

Printed Name of Patient or Guardian

Relationship to Patient

Assignment of Benefits

I hereby assign to Jeff L Johnson MD, PA, any insurance or other third-party benefits available for health care services provided to me. I understand that Jeff L Johnson MD, PA, has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Jeff L Johnson MD, PA, I agree to forward Jeff L Johnson MD, PA, all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

Signature of Patient or Guardian

Date

Printed Name of Patient or Guardian

Relationship to Patient

Consent to Treat

I (or my legal guardian or parent) authorize Jeff Johnson MD, PA, to provide medical care reasonable by today's standards.

Signature of Patient or Guardian

Date

Printed Name of Patient or Guardian

Relationship to Patient