Consent to Release of Information for Treatment, Payment, and Health Care Operations

I consent to the use and disclosure of my treatment information (or of the named patient for whom I am the parent or legal guardian) by BMHC for the following purposes:

- **Providing treatment** by BMHC staff or providing treatment information, including treatment records, to other health providers or agencies that are or will be involved in my care, including pharmacies; treatment may include health screening, diagnosis, medical treatment, laboratory procedures, minor or emergency surgical treatment, and/or mental health and drug and alcohol screening assessment, diagnosis and treatment.
- **Obtaining payment** for health care bills, including sending such treatment information and records as is needed to secure payment for BMHC services to the insurance company, worker's compensation company or agency that pays for my health services, as identified in my BMHC Registration form or other updated insurance information on file with BMHC; I hereby acknowledge the release of my medical records to third party insurers or authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insurers, or for work related injury to my employer or designee. I acknowledge that patient records may be stored electronically and made available through computer networks.
- **Conducting health care operations** of BMHC include but are not limited to: release of my medical information to any of my physicians and their offices or insurance companies participating in my care or treatment and the quality of that care and obtaining my medication history from pharmacies.

I understand that this is given in advance of any specific diagnosis or treatment and that these services are voluntary and that I have the right to refuse these services. I understand that I have the right to revoke this consent at any time, in writing, but revoking this consent will not affect any actions which were taken by Better Me Healthcare in reliance on this consent before I revoked it. I understand that I may request restrictions on use or disclosure of treatment records and information for the purposes described in this consent and that BMHC may or may not agree to the requested restrictions. I also understand that except for those restrictions on use or disclosure of treatment records and information to which it agrees, BMHC will not be able to provide services to me (or the named patient) without this signed consent. I also understand that BMHC may not disclose treatment information contained in psychotherapy notes or for marketing purposes without my written agreement in a separate Authorization. A photocopy of this consent shall be considered as valid as the original.

Medicare Lifetime Authorization

I certify that the information given to me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration of its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payments of authorized benefits be paid on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment. I request this authorization also apply to all other insurances.

Release of Medical Information to Family and Others

I give permission for my protected health information to be disclosed for purposes of communicating results, findings, and care decisions to the family members and others listed below. I understand that I may request individuals to leave the exam room at any time. I also understand that I must notify the office if any of the information below changes.

Name of Person who is Authorized to receive information	**Release information**	**Allowed in Exam Room**
_____	Y ◯ N ◯	Y ◯ N ◯
_____	Y ◯ N ◯	Y ◯ N ◯
_____	Y ◯ N ◯	Y ◯ N ◯

If the requestor/receiver of information is not a healthcare provider, the released information may no longer be protected from re-disclosure

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient/Guardian Signature: _____ **Date:** _____