Consent Form
Hilliard Family Medicine, Inc.

I consent to the use or disclosure of my protected health information by **Hilliard Family Medicine, Inc.** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Hilliard Family Medicine, Inc.** I understand that diagnosis or treatment of me by the staff of **Hilliard Family Medicine, Inc.** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Hilliard Family Medicine, Inc.** is not required to agree to the restrictions that I may request. However, if **Hilliard Family Medicine, Inc.** agrees to a restriction that I request, the restriction is binding on **Hilliard Family Medicine, Inc.**

I have the right to revoke this consent, in writing, at any time, except to the extent that **Hilliard Family Medicine, Inc.** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Hilliard Family Medicine, Inc.'s Notice of Privacy Practices prior to signing this document. The Hilliard Family Medicine, Inc.'s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Hilliard Family Medicine, Inc. The Notice of Privacy Practices for Hilliard Family Medicine, Inc. is posted in the reception room of Hilliard Family Medicine, Inc. and on the Hilliard Family Medicine, Inc.'s website at www.hilliardfamilymedicine.com. This Notice of Privacy Practices also describes my rights and the Hilliard Family Medicine, Inc.'s duties with respect to my protected health information.

Hilliard Family Medicine, Inc. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the Hilliard Family Medicine, Inc.'s website, by calling the office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____ _____
Birth Date Social Security Number/Account Number

_____
Date

Rev. 041403