CONSENT FOR TREATMENT, PAYMENT, HEALTHCARE OPERATIONS

I authorize Rogue Community Health to **use and disclose** the health and medical information of

_______________________________________ for the purposes of Treatment, Payment and Health Care Operations.

- **Treatment** (includes activities performed by a provider, nurse, lab personnel, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any medical personnel who covers our practice by telephone as the on-call medical personnel.

- **Payment** (includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre- authorization).

- **Health Care Operations** (includes the necessary administrative and business functions of our office). Rogue Community Health is part of an organized health care arrangement including participants in the Oregon Community Health Information Network (OCHIN). Your health information may be shared by Rogue Community Health with other OCHIN participants when necessary for health care operations.

You may review Rogue Community Health's "**Notice of Privacy Practices**" for the additional information about the uses and disclosures of information described in the CONSENT prior to signing this CONSENT. Please verify that you have received a copy of our **Notice** by placing your initials here:_______.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the **Notice** may change also. A summary of the **Notice** will be posted in our waiting room and web site indicating the effective date of the **Notice** in the upper right hand corner. We will offer you a copy of the **Notice** on your first visit to us after the effective date of the then current **Notice**. We will also provide you with a copy of the **Notice** upon your request.

As more fully explained in the **Notice**, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. **We are not required to agree to your request**. If we do agree, we are required to comply with you request unless the information is needed to provide you emergency treatment. Other medical personnel who provide call coverage for our office are required to use and disclose your protected health information consistent with the **Notice**.

I understand that I have the right to revoke this CONSENT provided that I do so in writing, except to the extent that Rogue Community Health has already used or disclosed the information in reliance on this CONSENT.

___________________   ____ (or)
(Date)   (Signature of patient)

___________________   ____
(Date)   (Signature of person authorized by law)