



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

You are receiving healthcare services from Tuscaloosa Med Center South, PC. You agree that all records concerning your care within TUSCALOOSA MED CENTER SOUTH, PC shall remain the property of TUSCALOOSA MED CENTER SOUTH, PC. You understand and agree that such information is used for: (1) your treatment - the provision and coordination of your healthcare which may require disclosure of all or any portion of your medical record information to your attending physician, consulting physician(s) and other health care providers who have a legitimate need for such information in the care and continued treatment of the patient, (2) payment for your services - billing, claims management, medical data processing, reimbursement and for determining coverage which may necessitate disclosure of such information to any insurance company, third party payor or other entity (or their authorized representatives), including any copies or excerpts of your medical record which are necessary for payment of patient's account, (3) routine healthcare operations -including, but not limited to, quality assurance, utilization review, medical review, internal auditing, accreditation, certification, licensing or credentialing activities of TUSCALOOSA MED CENTER SOUTH, PC; and (4) medical research and educational purposes. You acknowledge that you have been provided with a TUSCALOOSA MED CENTER SOUTH, PC Notice of Health Information Practices that provides a more complete description of the uses and disclosures of the patient's healthcare information, and that the Notice has been reviewed prior to the signing of this consent. You understand that TUSCALOOSA MED CENTER SOUTH, PC reserves the right to change the Notice and that TUSCALOOSA MED CENTER SOUTH, PC will provide you with a revised Notice when you come to TUSCALOOSA MED CENTER SOUTH, PC. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Restrictions Requested: _____

TUSCALOOSA MED CENTER SOUTH, PC: ___Agree ___Not Agree ___N/A

Patient Signature: _____

Date: _____

Witness Signature: _____

Date: _____