

**Consent for Purpose of Treatment, Payment
and Healthcare Operations**

9/06

I consent to the use or disclosure of my protected health information by V. Daniel Kassicieh, D.O. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by V. Daniel Kassicieh, D.O. may be conditioned upon my consent as evidence by my signature on this document.

I understand that 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. V. Daniel Kassicieh, D.O. is not required to agree to the restrictions that I may request. However, if V. Daniel Kassicieh, D.O. agrees to a restriction that I request, the restriction is binding on V. Daniel Kassicieh, D.O.

I have the right to revoke this consent, in writing, at any time, except to the extent that V. Daniel Kassicieh, D.O. has taken action in reliance on this consent.

My “protected health information” means health information, including 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 clearing house. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or if there is a reasonable basis to believe the information may identify me.

I understand that I have a right to review V. Daniel Kassicieh, D.O.’s Notice of Privacy Practices prior to signing this document. V. Daniel Kassicieh, D.O.’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 V. Daniel Kassicieh, D.O. The Notice of Privacy Practices for V. Daniel Kassicieh, D.O. is also provided in the patient waiting room and in patient exam rooms. This Notice of Privacy Practices also describes my rights and V. Daniel Kassicieh, D.O.’s duties with respect to my protected health information.

V. Daniel Kassicieh, D.O. 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 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 (Representative’s Authority)

Name of Patient or Personal Representative

Date