GREAT MINDS

…fostering success in development, learning and living

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I, _____, understand that as part of my healthcare, Great Minds of Michigan PLLC (herein referred to as "GREAT MINDS") originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

1. A basis for planning my care and treatment
2. A means of communication among the many health professionals who contribute to my care
3. A source if information for applying my diagnosis and medical information to my bill
4. A means by which a third-party payer can verify that services billed were actually provided, and
5. A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of how GREAT MINDS will use and disclose my health information in connection with my treatment, payment of my bills or the performance of healthcare operations as described above. I understand that I have the right to review the Notice prior to signing this consent.

I understand GREAT MINDS reserves the right to change its Notice and Privacy Practices and will provide to me prior to my next visit/treatment a copy of any revised notice, or upon my request.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations. I understand GREAT MINDS is not required to agree to the restrictions requested but that if GREAT MINDS does agree to a restriction, it will abide by it.

I understand that I may revoke this consent in writing, except to the extent GREAT MINDS has already taken action in reliance on it.

I understand GREAT MINDS will not provide service to me if I decline the terms of this consent.

I wish to have the following restrictions to the use or disclosure of my health information:
(If none, write NONE.)

I fully understand and accept/decline (circle one) the terms of this consent.

Signature:_____ Date:_____

Last revision 03/06/2011