PROHEALTH
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# PATIENT CONSENT FORM TP USE AND DISCLOSE PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

By signing this form, you are granting consent to ***Prohealth Advanced Imaging Institute*** to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our *"Notice of Privacy Practices"* provides more detailed information about how may use and disclose this protected health information. You have a legal right to review out "Notice of Privacy Practices" before you sign this consent and we encourage you to read it in full.

You have the right to request us to restrict how we use and disclose your protected health information for the purpose of treatment, payment or health care operation. We are not required by the law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

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***Prohealth Advanced Imaging Institute*** may disclose personal health information about you to your family, close personal friends, or any person that you identify, as long as the information disclosed to those individuals relevant to their involvement in your care or the payment for your ***Prohealth Advanced Imaging Institute*** also may notify a family member or another person who is responsible for your care of your location and general health condition. Please initial on the following to indicate your choice regarding such disclosures.

o I do not object my personal health information being disclosed to a family member friend, or another individual in my care.

o I object to my personal health information being disclosed to a family member friend, or another individual in my care.

_____ _____

Patient Name Date

_____ _____

Signature of Patient or Patient Representative Date