<u>CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS</u>

I hereby consent to the use or disclosure of my identifiable health information (“”protected health information”) by Biltmore Medical Associates, hereafter referred to as BMA, in order to carry out treatment, payment or health care operations. I have received BMA’s *Notice of Privacy Practices for Protected Health Information* and I have the right to review such Notice prior to signing this consent form.

BMA reserves the right to change the terms of its *Notice of Privacy Practices for Protected Health Information* at any time. If BMA does change the terms of its *Notice of Privacy Practices for Protected Health Information*, I may obtain a copy of the revised Notice by written request to the Administration office of BMA.

I retain the right to request that BMA further restricts how my protected health information is used or disclosed to carry out treatment, payment or health care operations. BMA is not required to agree to such requested restrictions; however, if they do agree to requested restrictions, such restrictions are then binding on BMA.

At all times, I will retain the right to revoke this Consent. Such revocation must be submitted to BMA in writing. The revocation shall be effective except to the extent that BMA has already taken action in reliance on the consent.

BMA may refuse to treatment if I (or an authorized representative) do not sign this Consent Form (except to the extent that BMA is required by law to treat individuals). If I (or authorized representative) sign this Consent Form and then revoke Consent, BMA has the right to refuse to provide further treatment as of the time of revocation (except to the extent that BMA is required by law to treat individuals).

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF <u>BMA’S NOTICE OF PRIVACY PRACTICES SUMMARY</u> ***AND I AM THE PATEINT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATEINT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.***

Date: ___________________ Time: ___________________ a.m. / p.m.

____ _________________________

Signature of Patient or *Authorized Representative *Relationship to Patient

____ _________________________

Please print name of Patient or *Authorized Representative *Relationship to Patient

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Signature of Witness

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Please print name of Witness