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

I hereby acknowledge receipt of written notice of my privacy right and I consent to DUBLIN FAMILY CARE, INC. using and disclosing my protected health information to carry out treatment, payment, or health care options.

I understand and have been provided with a *Notice of Privacy Practices*, which provides a more complete description of how my protected health information may be used or disclosed. I understand that I have the right to review the notice prior to signing this consent.

I understand that DUBLIN FAMILY CARE, INC. reserves the right to change their notice and information practices and that I may obtain a copy of the revised notice by written request addressed to JOSEPH CARDUCCI, MD. c/o DUBLIN FAMILY CARE, INC., 205 W. BRIDGE STREET #101, DUBLIN, OH 43017.

I understand that I have the right to restrict how DUBLIN FAMILY CARE, INC. uses or discloses my protected health information to carry out treatment, payment or health care operations; that DUBLIN FAMILY CARE, INC. is not required to agree to the restrictions and; that DUBLIN FAMILY CARE, INC. is bound by restrictions to which it agrees.

I consent to all payments for these services to DUBLIN FAMILY CARE, INC. I understand that I am responsible for all co-payments, amounts applied to deductibles and other amounts that may be deemed my responsibility by the payment sources as required by my contract with my insurance plan and state regulation. I further understand that my contract with my insurance entity may or may not cover some services: BWC claims, self-insured organizations, and auto accidents. If your account is sent to a collection agency a **50% surcharge** will be added to the balance due. IT IS MY RESPONSIBILITY TO OBTAIN INFORMATION FROM MY HEALTH PLAN ABOUT SERVICE COVERAGE. If I seek care outside of the contract, I am aware that I may be responsible for all charges that are incurred.

We participate in one or more Health Information Exchanges. Your healthcare providers can use this electronic network to securely provide access to your health records for a better picture of your health needs. We and other healthcare providers, may allow access to your health information through the Health Information Exchange for treatment, payment or other healthcare operations. This is a voluntary agreement. You may opt-out at any time by notifying the Health Information Management Services/Medical Records Department OR the office administrator. ☐ I wish to opt out of Health Information Exchanges at this time

I request the following restrictions to how my health information is used or disclosed:

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I have the right to revoke this consent by notifying DUBLIN FAMILY CARE, INC. in writing, except to the extent that DUBLIN FAMILY CARE, INC. has taken action in reliance on my consent.

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Signature of patient or patient's representative	Date
____________________________	________________________
Printed name of patient or patient's representative	Relationship to patient or representative's authority to act for the patient