Consent for Purpose of Treatment, Payment, and Healthcare Operations

I consent to the use or disclosure of my protected health information by the medical practice of Southwest Heart & Lung (SWHL) for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of the medical practice of SWHL. I understand that diagnosis or treatment of me by SWHL may be conditioned upon my consent as evidenced by my signature on this document.

I understand 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. The medical practice of SWHL is not required to agree to the restrictions that I may request. However, if the medical practice of SWHL agrees to a restriction that I request, the restriction is binding on the medical practice of SWHL.

I have the right to revoke this consent, in writing, at anytime, except to the extent that the medical practice of SWHL has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review the medical practice of SWHL's Notice of Privacy Practices prior to signing this document. The medical practice of SWHL's 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 healthcare operations of the medical practice of SWHL. This Notice of Privacy Practices also describes my rights and the medical practice of SWHL's duties with respect to my protected health information.

The medical practice of SWHL 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 contacting the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____	_____
Patient Name Printed	Signature of Patient
_____	_____
Date	Signature of Parent /Guardian of Minor Patient
_____	_____
Physician Name Printed	Physician Signature