Aurora Clinic

Treatment, Payment, or Healthcare Operations Consent Form

Patient Name:_____ Med.#_____

SS#:_____ **D.O.B** _____

1. I understand that as part of my health care, Aurora Clinic originates, records, and maintains health information about me describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this health information may be used or disclosed by Aurora Clinic for treatment, payment, and health care operations as described in Aurora's Notice of Privacy Practices.
2. I acknowledge that I have been provided with Aurora's *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the Notice of Privacy Practices prior to signing this consent. I understand that Aurora reserves the right to change its Notice of Privacy Practices and I can obtain a revised copy from Aurora Clinic. _____Patient Initial on Receipt
3. 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 health care operations, as described in Aurora's Notice of Privacy Practices. Aurora Clinic is not required to agree to the restrictions requested, but if it does, it is bound by such restrictions.
4. I understand that I may revoke this consent in writing, except to the extent that Aurora Clinic has already taken action in reliance thereon. This consent supersedes any prior consents.

COMMENTS:

_____

_____

Consent Effective Date

_____ _____

Signature of Patient or Guardian/Legal Representative Date

_____ _____

Signature of Witness Date