Patient Consent for Use and Disclosure of Health Information

Steadfast Family Medicine

This consent form explains how **Steadfast Family Medicine** may use and disclose your protected health information (PHI) and documents your consent as a patient.

🔒 Purpose of This Consent

Steadfast Family Medicine is required by law to protect the privacy of your health information. This consent allows the practice to use and disclose your protected health information for purposes related to your care and the operation of the practice.

🧑‍⚕️ Uses and Disclosures of Health Information

By signing this form, you consent to Steadfast Family Medicine using and disclosing your protected health information for the following purposes:

🏥 Treatment

- Sharing information with physicians, nurses, medical assistants, specialists, laboratories, pharmacies, hospitals, and other healthcare providers involved in your care

🧾 Payment

- Submitting claims to insurance companies
- Verifying coverage and benefits
- Billing and collection activities

🏢 Healthcare Operations

- Quality assessment and improvement activities
- Care coordination

- Practice management, administrative, and compliance activities

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📪 Other Permitted Disclosures

Your information may also be disclosed when required or permitted by law, including:

- Public health reporting
- Health oversight activities
- Legal or regulatory requirements
- To prevent a serious threat to health or safety

🚫 Uses and Disclosures Requiring Authorization

Uses or disclosures of your health information **outside of treatment, payment, or healthcare operations** generally require your written authorization, unless otherwise permitted or required by law.

You may revoke an authorization at any time in writing, except to the extent action has already been taken.

🔎 Your Rights Regarding Health Information

You have the right to:

- Request restrictions on certain uses or disclosures of your health information
- Request confidential communications
- Inspect and obtain a copy of your medical records
- Request amendments to your medical records
- Receive an accounting of certain disclosures

A complete description of your rights is provided in the **Notice of Privacy Practices**, available upon request.

✍️ Acknowledgment and Consent

By signing below, you acknowledge that:

- You have been provided access to the Steadfast Family Medicine Notice of Privacy Practices
- You understand and consent to the use and disclosure of your protected health information as described above

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Patient Information

Patient Name (Print):
[_____]

Date of Birth:
[____ / ____ / _____]

Signature

Patient or Legal Representative Signature:
[_____]

Printed Name (if signed by representative):
[_____]

Relationship to Patient:
[_____]

Date:
[____ / ____ / _____]

This consent remains in effect unless revoked in writing. A copy of this signed consent will be maintained in your medical record.