SUZANNE GAZDA M.D.
INTEGRATIVE NEUROLOGY

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I,_____, understand that as part of my healthcare this office originates and maintains paper and/or electronic records describing my health history, symptoms, examination, and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A source for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of health care professionals.

I have been provided with a summary Notice of Information Practices that provides a more complete description of the uses and disclosures of my health information. YOU have the right to ask for a new review a full copy of the Notice of Privacy Practices document. I understand that I have rights under the HIPAA regulations. I may revoke this consent at any time, provided that such revocation is in writing and presented to any of the office staff.

I understand that Suzanne Gazda M.D. Integrative Neurology has established a Notice of Privacy Practices which provides information about how a patient's protected health information, including Rx and billing, can be used and disclosed. I consent to the use of my protected health information for the treatment, payment, and health care options.

I give you permission to call, speak with, and/or release any health information to the following person (s):

_____

_____

I fully understand and accept terms of this consent.

_____ _____

Patient/Guardian Signature Date

RESET SUBMIT PRINT

_____

Office Use Only

☐ Consent added to the patient's medical record on _____