METRO ANESTHESIA & PAIN MANAGEMENT

Consent to Use and Disclosure of Protected Health Information for Treatment, Payment and Health Care Operations

I consent to allow Metro Anesthesia to use or disclose my protected health information for treatment, payment and healthcare operations.

- Treatment means the provision, coordination, or management of health care and related services by one or more health care providers.
- Payment means the activities undertaken by a health care provider or health plan to obtain or provide reimbursement for the provision of health care.
- Health Care Operations means conducting quality assessment and improvement activities; reviewing the competence or qualifications of health care professionals; underwriting; premium rating; and other activities related to health insurance contracts; medical reviews; legal services; auditing functions; and business management and general administrative activities of Metro Anesthesia.

I have been informed of and given the right to review and secure a copy of Metro Anesthesia & Pain Management's Notice of Privacy Practices prior to signing this Consent. Such Notice of Privacy Practices contains a more complete description of the uses and disclosures of my protected health information and my rights with respect to my medical information. I understand that Metro Anesthesia & Pain Management has the right to revise its privacy practice and to amend the Notice. I have been informed that in the event Metro Anesthesia & Pain Management revises it privacy practices, a revised notice will be posted at 2459 East Euclid Suite B, Des Moines, IA and 5901 Westown Pkwy. Suite 210, West Des Moines, IA, and that I may obtain a current Notice at any time from either location.

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. I understand that I may revoke this Consent only in a writing sent certified mail to Metro Anesthesia & Pain Management. I further understand that Metro Anesthesia & Pain Management does not have to agree to such restrictions. If Metro Anesthesia & Pain Management agrees to the restriction in writing, it is binding. I understand that the revocation or restriction will be effective only upon receipt and will not apply to information that has already been used or disclosed in accordance with this Consent. I understand that the revocation or restriction will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

_____ _____

Signature of Patient/Representative and Relationship if applicable _____

Date

Patient Financial Responsibility for Copayments and Other Amounts

My signature below forms a binding agreement between me and Metro Anesthesia & Pain Management. I agree to pay any required copayment, or other amounts not covered by insurance, at the time such payment is requested.

_____ _____

Signature of Patient/Representative and Relationship if applicable _____

Date