



**Parkview Health Services of New York LLC**  
**Consent To Use and Disclose Protected Health Information For**  
**Treatment, Payment and Health Care Operations**

**Section A: Uses and Disclosures**

I authorize the use and disclosure of my Protected Health Information by Parkview Health Services of New York LLC located at 1770 Colvin Boulevard, Buffalo, New York 14223 (“Parkview”) as listed below and by its workforce members, health care professionals and vendors providing services or supplies to me for purposes of treatment, payment and health care operations.

**Section B: Important Information Regarding this Consent**

1. I understand state laws require my consent before Parkview may use or disclose my Protected Health Information for Parkview’s treatment, payment or health care operations.
2. I understand that this information may be used or disclosed by Parkview to:
  - ◆ provide for my care and treatment, including the filling and supplying of prescriptions;
  - ◆ communicate among various health care professionals who are involved in my care or treatment;
  - ◆ obtain payment for care and treatment provided by Parkview or for the payment activities of another health care provider or entity;
  - ◆ provide information to my health insurance company or plan;
  - ◆ obtain payment from my health insurance company or plan;
  - ◆ assess and review the quality of my care; and
  - ◆ conduct its business and health care operations.
3. I understand that my signature on the consent is required in order for me to receive care and treatment from Parkview and that Parkview may condition my treatment on obtaining my consent for use and disclosure of my Protected Health Information for its treatment, payment and health care operations.
4. I understand that further information on Parkview’s uses and disclosures of my Protected Health Information is included in Parkview’s Notice of Privacy Practices.

**Parkview Health Services- Protected Health Information Consent and Acknowledgement**

Individual's Name: \_\_\_\_\_

Agency/ Home: \_\_\_\_\_

**SIGNATURE**

I have read and understand the terms of this consent. I have had an opportunity to ask questions about the use or disclosure of my Protected Health Information.

Print Beneficiary Name: \_\_\_\_\_

Signature of Patient or Personal Representative: \_\_\_\_\_

Print Name of Personal Representative: \_\_\_\_\_

Date: \_\_\_\_\_

Description of Personal Representative's Authority: \_\_\_\_\_

**CONTACT INFORMATION**

Contact information of the personal representative who signed this form:

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ (Daytime) \_\_\_\_\_ (Evening)

**II. Acknowledgement of Receipt of Notice of Privacy Practices**

I acknowledge that I have received a copy of Parkview's Notice of Privacy Practices and have been advised of how Parkview will handle my Protected Health Information. I have also been advised of my rights to obtain access to and control my Protected Health Information. I understand that I may receive other notices which describe how Parkview will handle specialized forms of Protected Health Information such as HIV/AIDS-related, alcohol and drug abuse information.

**SIGNATURE**

Signature of Patient or Personal Representative: \_\_\_\_\_

Print Name of Patient or Personal Representative: \_\_\_\_\_

Date: \_\_\_\_\_

**Please complete and fax to: 716-876-1349**