Parkview Health Services, 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, LLC located at 3920 Main Street Suite 100, Amherst, New York 14226 ("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.

Print Individual's Name: _____

Print Agency/ Home/Location: _____

Please complete BOTH signature boxes (Part I and Part II)

Part I. Consent to disclose Protected Health Information

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.

Signature of Individual or Personal Representative:_____

Date: _____

If Signed by a Personal Representative, Complete the Following:

Print Name of Personal Representative:_____

Description of Personal Representative's Authority:_____

CONTACT INFORMATION

Contact information of the personal representative who signed this form:

Address:_____

_____

Telephone: _____(Daytime) _____(Evening)

Part 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

Print Name of Patient or Personal Representative:_____

Signature of Patient or Personal Representative:_____

Date: _____

Please complete and fax to: 716-876-1349