

**PATIENT CONSENT TO THE USE AND PROCEDURE OF HEALTH INFORMATION  
FOR TREATMENT OF PATIENT OR HEALTHCARE OPERATIONS**

\_\_\_\_\_, understands that as a part of my health care, **Dr. LeNoir & Associates** originates, maintains paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis 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, and
- A tool for routine healthcare operations such as assessing quality and review in the competence of healthcare professionals.

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I understand that **Dr. LeNoir & Associates** is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by section 164.506 of the Code of Federal Regulations.

I further understand that **Dr. LeNoir & Associates** reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should \_\_\_\_\_ change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

\_\_\_\_\_  
\_\_\_\_\_

I understand that as part of this organization's treatment payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and **accept/decline** the terms of this consent.

\_\_\_\_\_  
**Patient's Signature (authorized representative signing for the patient)**

\_\_\_\_\_  
**Date**

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**FOR OFFICE USE ONLY**

- [ ] Consent received by \_\_\_\_\_ on \_\_\_\_\_.
- [ ] Consent refused by patient, and treatment refused as permitted.
- [ ] Consent added to the patient's medical record on \_\_\_\_\_.