Derrol M. Sillito, D.C.

General Consent for Purposes of Treatment, Payment and Healthcare Operations

I hereby consent to the use and/or disclosure of my protected health information by Derrol M. Sillito, D.C. and staff for the purpose of Treatment, Payment, and Healthcare Operations. I understand that protected health information includes the following:

*All and any of my personal health records
*Demographic information
* Examination and test results
*Diagnosis
*Treatment
*Plans for future medical care

And that this information serves as:

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

I further understand that:

*Derrol M. Sillito, D.C. originates and maintains protected health information as part of my healthcare including but not limited to information that may have been obtained from another healthcare provider, clearinghouse, health plan or employer
* I have the right to review Derrol M Sillito D.C. Notice of Privacy Practices before I sign this document.
* I have the right to request a restriction as to how my protected healthcare information is used carry out treatment, payment, or healthcare operations however, Derrol M. Sillito D.C. is not required to agree to the restriction request.
* I have a right to revoke this consent at anytime in writing. However it will not affect any actions taken before the revocation was received or actions taken in reliance thereon.
* Derrol M. Sillito D.C. reserves the right to change their notice of privacy practices at anytime. I have the right to obtain a copy of any revised notice upon request.

Restrictions

[ ] No restrictions requested

[ ] I request the following restrictions on the use or disclosure of my health information

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_____

Patient Name:_____ Date_____

Patient Signature_____

Signature of Witness_____ Date_____