DOWNEAST ORTHOPEDIC ASSOCIATES

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I consent to Downeast Orthopedics use and disclosure of my protected health information ("PHI") in support of my diagnosis and treatment, payment for the medical services I receive, and the legitimate health care operations of the medical practice.

I consent to Downeast Orthopedics disclosure of PHI to other health care practitioners and facilities that are involved in providing medical services to me and to my family and close friends who are providing me with emotional support as I receive medical services. Also, I consent to Downeast Orthopedics disclosure of PHI to my health insurance carrier, utilization review organization, or third-party administrator to support payment for my medical services.

I understand that Downeast Orthopedics will disclose only the minimum amount of my health care information which is necessary, in the judgement of Downeast Orthopedics, for the legitimate needs of the recipient or my general well being.

My PHI which is the subject of this consent includes demographic information; information about my physical or mental health condition; information about the medical services provided to me. Depending upon the medical services I request or require this information may include information about treatment for HIV/AIDS, sexually transmitted diseases, mental health or psychiatric conditions, or substance abuse.

I understand that I have a right to restrict Downeast Orthopedics use and disclosure of my PHI and that Downeast Orthopedics is not obligated to agree to the requested restriction, but that an agreement to a restriction binds Downeast Orthopedics . I may revoke this consent at any time by providing Downeast Orthopedics with a written, signed, and dated request. However, I understand that any restriction on the use and disclosure of PHI or revocation of this consent may result in improper diagnosis or treatment, denial of coverage of a claim for insurance benefits, or other adverse consequences.

This consent will remain in effect for all subsequent uses and disclosures for the limited purposes outlined above for 30 months from the date of this consent unless I revoke it earlier as described above.

Downeast Orthopedics regards the safeguarding of PHI as an important duty. The elements of this consent are required by state and federal law for your protection and to ensure your informed consent to the use and disclosure of PHI necessary to support my relationship with Downeast Orthopedics.

Should you have any questions about this consent or about Downeast Orthopedics privacy practices, or if you wish to have a copy of this consent, please ask the office staff or the practice administrator.

I acknowledge receipt of the Notice of Privacy Practices prepared by Downeast Orthopedics by signing below. Also, I acknowledge that I have had an opportunity to ask questions about the practice's Notice of Privacy Practices.

_____ **Date:**_____

Signature of Patient or Parent/Legal Guardian

_____

Printed Name