18522 US Highway 18, Suite 102, Apple Valley, CA 92307

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT OR HEALTHCARE OPERATIONS

I, _____, understand that as part of my healthcare, this practice maintains health records describing my health history, symptoms, test results, treatment and plans for future care. I understand that this information services as:

Patient Name, (if minor or dependent): _____ D.O.B.: _____

- A basis for planning my care.
- A means of communication among the many health care 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.
- A tool for routine healthcare operations such as assessing quality, etc.

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

(this is where you may add a family or friends name for release of information as well.)

I have received a copy of the Notice of Practice Practices from Meridian Urgent Care & Occupational Health Center, Inc.

_____ _____

Name Date