

**Consent for Purposes of Treatment, Payment and Health Care Operations**

I consent to the use or disclosure of my protected health information by **Lakeshore Tubal Reversal Center** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Lakeshore Tubal Reversal Center**.

I understand that diagnosis or treatment of me by **Lakeshore Tubal Reversal Center** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. **Lakeshore Tubal Reversal Center** is not required to agree to the restrictions that I may request. However, if **Lakeshore Tubal Reversal Center** agrees to a restriction that I request, the restriction is binding on **Lakeshore Tubal Reversal Center**.

I have the right to revoke this consent, in writing, at any time, except to the extent **Lakeshore Tubal Reversal Center** has taken action in reliance on this consent.

My "Protected Health Information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **Lakeshore Tubal Reversal Center's** Notice of Privacy Practices prior to signing this document.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of **Lakeshore Tubal Reversal Center**.

The Notice of Privacy Practices for **Lakeshore Tubal Reversal Center** is also provided upon request.

The Notice of Privacy Practices also describes my rights and the duties of **Lakeshore Tubal Reversal Center** with respect to my protected health information.

**Lakeshore Tubal Reversal Center** reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

\_\_\_\_\_  
Signature of Patient/Personal Representative

\_\_\_\_\_  
Print Name of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness