# NEW GARDEN PSYCHIATRY - *Consent for Use or Disclosure of Health Information*

We here at **New Garden Psychiatry.** are very concerned with protecting your privacy. While the law require us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information. There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.

- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.

- We may need to use your health information within our practice for quality control or other operational purposes such as recall notices, reminder calls, and treatment news.

**New Garden Psychiatry**, its staff or employees, may from time to time schedule appointments for other healthcare providers, when requested. These providers are not partners or contractors of **New Garden Psychiatry**. All health and patient information disclosed to **New Garden Psychiatry**, its employees or staff, shall remain confidential and we will ensure that all federal and state laws pertaining to confidentiality of patient health information, including HIPAA are complied with.

**Your right to limit uses or disclosures**

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions other use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

**Your right to revoke your authorization**

You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

**PATIENT SIGNATURE OR PATIENT AUTHORIZED REPRESENTATIVE**

_____ **DATE:** _____

I HEREBY AUTHORIZE THE FOLLOWING PEOPLE TO OBTAIN AND DISCUSS MY MEDICAL INFORMATION.

NAME_____ RELATIONSHIP_____ PHONE #_____

NAME_____ RELATIONSHIP_____ PHONE #_____

NAME_____ RELATIONSHIP_____ PHONE #_____

I HEREBY AUTHORIZE THE FOLLOWING PHYSICIANS TO OBTAIN AND DISCUSS MY MEDICAL INFORMATION.

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**PATIENT SIGNATURE OR PATIENT AUTHORIZED REPRESENTATIVE**

_____ **DATE:** _____