OMH Otsego Memorial Medical Group

Consent To The Use And Disclosure Of Health Information For Treatment, Payment And Healthcare Operations

I understand that as part of my healthcare, Otsego Memorial Hospital uses health information and medical records describing all aspects of my care. It is used for:

- Planning my care and treatment
- Communicating with health professionals involved in my care
- A source of information for billing
- A means by which any payer can verify that services billed were provided, and assist with our providers being paid for services and care provided to me; and
- A tool used for routine healthcare operations to measure the quality of my care

- I acknowledge that (1) if I am a first time patient, I was offered and have received a copy of Otsego Memorial Hospital's Notice of Privacy Practices; or (2) if I am not a new patient to Otsego Memorial Hospital, I have received a Notice of Privacy Practices at a previous visit.
- I understand that Otsego Memorial Hospital reserves **the right to change this notice** and will post a copy of any revised Notice in its waiting rooms and examination rooms and will provide me with a copy upon my request.
- I understand that **I have the right to object** to the use of my health information for directory purposes and to request restrictions as to how my health information is used or shared to carry out treatment, payment, or healthcare operations.
- I understand that **Otsego Memorial Hospital is not required to agree** to the restrictions requested.
- I understand that **I may cancel this Consent in writing**, except to the extent that Otsego Memorial Hospital has already used the information while the consent was active.

- The Notice of Privacy Practices is posted in a clear and prominent location where I am able to read the Notice
- I know that I can ask for a copy of the Notice of Privacy Practices to take with me
- I was able to view the Notice of Privacy Practices on the first day I received health care services
- I am able to view the Notice electronically at the OMH website and OMH Patient Portal
- If I came in for health care services in an emergency treatment situation, I was able to view the Notice as soon as reasonably practicable after the emergency treatment

_____ _____

Signature of Patient, Parent, or Legal Guardian Date

OTSEGO MEMORIAL MEDICAL GROUP

PATIENT PRIVACY AND PHONE MESSAGES

PATIENT NAME: _____**DATE OF BIRTH**_____
(Please Print)

FOR PEDIATRIC PATIENTS ONLY:

MOTHER (OR LEGAL DESIGNEE): _____
(Please Print)

FATHER (OR LEGAL DESIGNEE): _____
(Please Print)

HOW OUR OFFICE SHOULD REACH YOU:

What number should we call?		( ) HOME CELL WORK	
Is this your primary phone number?	YES No	May we leave a message or voice mail?	YES No
Are there other numbers we could use?	___No	( ) HOME CELL WORK	
		May we leave a message or voice mail?	YES No
		( ) HOME CELL WORK	
		May we leave a message or voice mail?	YES No

SHARE Otsego Memorial Hospital may share any health information about me with the following family members and/or friends who are or may be involved in my care:

FULL NAME

DO NOT SHARE MY HEALTH INFORMATION WITH THE FOLOWING:

FULL NAME

My signature below indicates I have completed the above sections to the best of my ability. I understand that I may change the responses provided at any time by making a change in writing.

_____ _____
Signature of Patient, Parent, or Legal Guardian Date

_____
Printed Name of Parent or Legal Guardian