MACON-BIBB COUNTY Health Department
Georgia Department of Public Health
North Central Health District
Serving the Community Since 1882

Macon-Bibb County Health Department
Travel Clinic
171 Emery Hwy., Macon, GA 31201
Phone: 478-749-0145
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NCHD52.org/Travel

Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

Patient Name: _____ **Date of Birth:** _____

I understand that as part of my healthcare, the Macon-Bibb County Health Department originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and treatment information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures.

I understand that:

- I have the right to review the notice prior to signing this consent.
- The organization reserves the right to change its notice and practices
- I will receive a revised notice at my next visit if any revisions are made to the notice.
- I have the right to object to the use of my health information for directory purposes.
- I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested.
- I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

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

_____

_____

_____ _____ _____

Signature of Legal Representative of Patient Named **Relationship to Patient** **Date**

_____ _____ _____

Witness **Title** **Date**