Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment or Health Care Operations by Stellar Rehabilitation, LLC

I, ______________________________, understand that as part of my health care, Stellar Rehabilitation creates and maintains paper and/or electronic records about my health history; including but not limited to, symptoms, examination and test results, diagnoses, treatment and plans for future care or treatment. I understand this information serves as:

- A basis for planning my care and treatment,
- A means of communicating with other health professionals who may contribute to my care, including the physician that referred me for treatment if applicable,
- A source of information for applying my diagnosis and medical information to my bill,
- A means by which I or a third-party payer, such as my medical insurer, can verify that the services billed were actually provided, and,
- A tool for routine health care operations such as assessing the quality of the care received and reviewing the competence of health care professionals

I have been provided with and understand the Privacy Notice that includes more information about the uses and disclosures of information by Stellar Rehabilitation, LLC. I understand I have the following rights regarding my medical information:

- The right to review the privacy notice, prior to signing this consent,
- The right to request restrictions as to how my health information may be used or disclosed by Stellar Rehabilitation to carry out treatment, payment and health care operations.
- The right to revoke this consent *in writing*, except to the extent that Stellar Rehabilitation and its business associates have already taken action in reliance of my consent.

I understand that Stellar Rehabilitation is not required to agree to any restrictions I may request. I understand that by refusing to sign this consent or revoking this consent, Stellar Rehabilitation may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Stellar Rehabilitation reserves the right to change their notice and privacy practices, in accordance with Section 164.520 of the Code of Federal Regulations. Should the practice change their notice, they will provide me with a copy of the revised notice to the address I have provided.

I understand that as part of this organizations treatment, payment or health care operations, it may become necessary to disclose my health information to a business associate or other entity, and I consent to such disclosure for these uses as allowed by law, including disclosures via fax.

____ ____________________________________

Patient/Guarantor/Personal Representative Signature Date

FOR OFFICE USE ONLY

[ ] Consent received by ______________________________ on ______________________________.

[ ] Consent refused by patient and treatment refused as permitted by CFR Section 164.506