ORANGE FAMILY PHYSICIANS
PROTECTED HEALTH INFORMATION (HIPPA)

I CONSENT TO THE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION BY ORANGE FAMILY PHYSICIANS AND ITS MEDICAL STAFF FOR THE PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

I give consent to Orange Family Physicians, it's Medical Staff, and other providers involved in my care to use and/or disclose my protected health information for the *purposes* of treatment, payment, and health care operations. I understand health care operations may include, among other, use and disclosures relative to quality review, utilization review, medical necessity, or legal review. Protected health information may include medical records, insurance and payment information, and other information used, in whole or in part, to make decisions about me. Orange Family Physicians Notice of Privacy Practices provides more information about how Orange Family Physicians, it's Medical Staff, and other providers may use and disclose my protected health information for these purposes.

I acknowledge that I have received or been offered a copy of Orange Family Physicians Notice of Privacy Practices.

Print name: _____ DOB: _____

Signed: _____ Witness: _____

Date: _____

If this notice is being signed on behalf of other family members, please list their Name, Date of Birth, and Relationship below.

Name	Date of Birth	Relationship