Consent for Purposes of
Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my Protected Health Information (PHI) as defined under the Federal HIPAA Privacy Rule (45 CFR, Parts 160 and 164), by Brookside Family Medicine, PLC; for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Brookside Family Medicine, PLC. I understand that diagnosis or treatment of me by the providers of Brookside Family Medicine, PLC may be conditioned upon my consent as evidenced by my signature on this document. I understand that the information in my health record may include information relating to sexually transmitted diseases, tuberculosis (TB), hepatitis B, acquired immunodeficiency syndrome (AIDS), and human immunodeficiency virus (HIV). These records may include information about behavioral or mental health services I have received, including any treatment for alcohol and drug abuse, which may include records protected under the regulations in 42 CFR, Part 2. I understand that the information in my health record may include information relating to psychological services records, including communications made by me to a social worker or psychologist, and that I specifically authorize the use and disclosure of psychotherapy notes pursuant to 45 CFR §164.508. I also specifically authorize the use and disclosure of records containing information relating to sexually transmitted diseases, behavioral or mental health services and drug and alcohol treatment and abuse.

I understand that Brookside Family Medicine, PLC has entered into an agreement with Munson Medical Center and Northern Physician Organization under which some elements of my PHI will be placed on a Community Electronic Medical Record. I further understand that healthcare providers in addition to the providers at Brookside Family Medicine, PLC will have access to my PHI on the Community Electronic Medical Record. I consent to my PHI being placed on the Community Electronic Medical Record for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, quality assessment monitoring or to conduct health care operations. I have the right to revoke this consent in writing at any time, except to the extent that the providers of Brookside Family Medicine, PLC have taken action in reliance on this consent under Federal. I understand that if I revode this consent my PHI will remain on the Community Electronic Medical Record. My PHI means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This PHI relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. I understand I have a right to review Brookside Family Medicine, PLC Notice of Privacy Practices prior to signing this document.

The Brookside Family Medicine, PLC's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my PHI that will occur in my treatment, payment of my bills or in the performance of health care operations of the Brookside Family Medicine, PLC. The Notice of Privacy Practices for Brookside Family Medicine, PLC is also provided in the main lobby of the office at 872 Munson Ave, Ste D, Traverse City, Ml and on the Brookside Family Medicine website at www.brooksidefamilymed.com. This Notice of Privacy Practices also describes my rights and the Brookside Family Medicine, PLC's duties with respect to my PHI. Brookside Family Medicine, PLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the Brookside Family Medicine's website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

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Signature of Patient or Personal Representative **Date**

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Printed Name