Alliance Medical Group, Inc.

CONSENT TO THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS (TPO)

Patient Name: _____Date of Birth:_____

I consent to the use or disclosure of my protected health information **Alliance Medical Group, Inc.** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Alliance Medical Group, Inc.** I understand that diagnosis or treatment of me by **Alliance Medical Group, Inc.** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Alliance Medical Group, Inc.** is not required to agree to the restrictions that I may request. However, if **Alliance Medical Group, Inc.** agrees to a restriction that I request, the restriction is binding on **Alliance Medical Group, Inc.**

I have the right to revoke this consent, in writing, at any time, except to the extent that **Alliance Medical Group, Inc.** has taken action in reliance on this consent.

My "protected health information" means my individually identifiable 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 protected health information 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 **Alliance Medical Group, Inc.** Notice of Privacy Practices prior to signing this document. **Alliance Medical Group, Inc.'s** Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of **Alliance Medical Group, Inc.** The Notice of Privacy Practices for **Alliance Medical Group, Inc.** is also posted at **Alliance Medical Group, Inc.** locations and on our website at **www.alliancemedicalgroup.com**. This Notice of Privacy Practices also describes my rights and **Alliance Medical Group, Inc.'s** duties with respect to my protected health information.

Alliance Medical Group, Inc. 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 **Alliance Medical Group, Inc.'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.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Name of Patient or Personal Representative Description of Personal Representative's Authority