Virginia Medical Alliance

vma

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by my physician at Virginia Medical Alliance, P.C. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care or to conduct health operations of Virginia Medical Alliance. P.C.

I have the right to revoke this consent in writing at any time, except for the extent that my physician or Virginia Medical Alliance, P.C. has taken action in reliance on this consent.

My "protected health information" (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 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 this information may identify me.

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Signature of Patient or Personal Representative

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Name of Patient or Personal Representative

_____

Date

_____

Description of Personal Representative/s Authority