DT46570

UPSTATE
UNIVERSITY HOSPITAL

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ MR#: _____

Account #: _____ DOB: _____ Date: _____

By signing below I agree that SUNY Upstate Medical University (Upstate), including University Hospital and its Medical Staff, may use and disclose my protected health information, as necessary, to treat my condition, obtain payment for treatment, and conduct normal business operations of Upstate. I understand that the information used and disclosed for these purposes may contain my name and/or other information that could be used to directly identify me.

I acknowledge that:

- Upstate will not withhold treatment if I do not sign this consent.
- If I choose to receive treatment without agreeing to sign this consent, it is understood that Upstate will need to use and disclose my protected health information in order to provide such treatment and obtain payment. My choice to receive treatment indicates my consent to Upstate to use and disclose my protected health information for these purposes.

By signing below, I also acknowledge that I have been provided a copy of Upstate's Notice of Privacy Practices which explains how my protected health information may be used and disclosed by Upstate, including University Hospital and members of its medical staff and how I may obtain access to and control the use and disclosure of my health information.

_____

Signature of Patient or Personal Representative

_____

Name of Patient or Personal Representative (Print)

_____

Date/Time

_____

Staff Member Name

Unable to obtain patient or personal representative signature due to:

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