

**GENERAL CONSENT TO USE AND DISCLOSE  
PROTECTED HEALTH INFORMATION**

This is a consent form. It permits Premier Orthopaedics & Sports Medicine Associates, LTD to use and disclose information about your health. This information is called “protected health information”. This is information we receive or create that identifies you and deals with your physical or mental health, any health care we provide to you, and/or payment for such health care.

By signing this form, you are consenting to our use and disclosure of your protected health information in order to carry out treatment, payment, or health care operations, as further explained in our “Notice of Privacy Practices” (the “Notice”).

By signing this form, you acknowledge that you have received or were offered our Notice. This Notice describes in detail how we might use or disclose your protected health information. The Notice discusses your rights and our duties with respect to your protected health care information. You have a right to review the Notice before signing this consent. You have a right to request that we restrict how we might use or disclose your protected health information to carry out treatment, payment, or health care operations. We are not however required to agree to requested restrictions. If we agree to requested restrictions, we are bound to adhere to them.

You have the right to revoke this consent, in writing, except where we have previously taken action in reliance on your prior consent.

If you refuse to sign this consent form, we will not be able to treat you.

\_\_\_\_\_  
Signature of Patient or Legally Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Legally Authorized Representative

\_\_\_\_\_  
Legal Relationship to Patient (e.g. Parent or Guardian)