

Primary Care Specialists, Inc.
190 Groton Road, Suite 110
Ayer, MA 01432
Telephone: 978-772-2780 Fax: 978-772-2780

**Consent to Use or Disclose Protected Health Information
For Treatment, Payment and Health Care Operations**

- Health care operations means conducting quality assessment and improvement activities; reviewing the competence or qualifications of health care professionals; underwriting, premium rating and other activities related to health insurance contracts; medical reviews; legal services; auditing functions; and business management and general administrative activities of *Primary Care Specialists, Inc.*
- Treatment means the provision, coordination, or management of health care and related services by one or more health care providers.
- Payment means the activities undertaken by a health care provider or health plan to obtain or provide reimbursement for the provision of health care.

I consent to allow *Primary Care Specialists, Inc.* to use or disclose my protected health information for treatment, payment and health care operations.

I consent to allow *Primary Care Specialists, Inc.* to disclose my protected health information for treatment activities of another health care provider.

I consent to allow *Primary Care Specialists, Inc.* to disclose my protected health information to another covered entity or another health care provider for the payment activities of the entity that receives the information.

I consent to allow *Primary Care Specialists, Inc.* to disclose my protected health information to another covered entity for health care operations activities, provided that *Primary Care Specialists, Inc.* and the other covered entity has or had a relationship with the below named patient. The disclosure must be for treatment, payment or health care operations or for the purpose of health care fraud and abuse detection or compliance.

I acknowledge that I have received a copy of *Primary Care Specialists, Inc.* Notice of Privacy.

Name of Patient: _____
(PLEASE PRINT)

Signature of Person Authorizing Consent	Relationship to Patient	Date
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Release of Information

I, _____, give permission for my medical/account information to be discussed with the following person(s):

Spouse: _____ Phone #: _____

Relative: _____ Phone #: _____

Other: _____ Phone #: _____

Signature: _____ Date: _____