Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Pacific Rim Electrophysiology 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 Pacific Rim Electrophysiology (EP) Medical Group, Inc. I understand that diagnosis or treatment to me by Pacific Rim EP 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. Pacific Rim EP is not required to agree to the restrictions that I may request. However, if Pacific Rim EP agrees to a restriction that I request, the restriction is binding on Pacific Rim EP and Koonlawee Nademanee, MD.

I have the right to revoke this consent, in writing, at any time, except to the extent that Pacific Rim EP has taken action in reliance on this consent.

My protected health information 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 healthcare 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 Pacific Rim EP s Notice of Privacy Practices prior to signing this document. Pacific Rim EP 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 Pacific Rim EP. A copy of The Notice of Privacy Practices for Pacific Rim EP is also provided to each patient at time of consultation. This Notice of Privacy Practices also describes my rights and Pacific Rim EP s duties with respect to my protected health information.

Pacific Rim EP 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 Pacific Rim EP s website, calling the office and requesting a revised copy sent in the mail or by asking for one at the time of my next appointment.

____

Signature of Patient or Personal Representative Date Signed

____

Printed Name of Patient or Personal Representative

____

Description of Personal Representative s Authority

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION

I authorize PACIFIC RIM ELECTROPHYSIOLOGY to use and disclose my medical for the purposes of Treatment, Payment and Health Care Operations*.

***Treatment** includes activities performed by a health care provider, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers my/our practice by telephone as the on-call physician.

***Payment** includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization.

***Health Care Operations** includes the necessary administrative and business functions of our office.

I further authorize **Koonlawee Nademanee, MD** to use and disclose the following specific health and medical information for the below listed purpose(s):

Specific medical information consisting of:

For the specific purpose of:

I understand that I have the right to revoke this Consent provided that I do so in writing, except to the extent that [Name of Health Care Provider] has already used or disclosed the information in reliance on this Consent.

Signature of Patient____

Signature of Person Authorized by Law____

Printed Name:____

Date__________________________________

PLEASE READ

If Pacific Rim Electrophysiology is requesting this Authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

- You may inspect a copy of the protected health information to be used or disclosed;
- You may refuse to sign this Authorization; and
- We must provide you with a copy of the signed authorization.

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.

Unless revoked earlier or otherwise indicated, this Authorization will expire 730 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

You may review Pacific Rim Electrophysiology's "Notice Of Privacy Practices" for additional information about the uses and disclosures of information described in this Consent prior to signing this Consent. Please verify that you have received a copy of our Notice by placing your initials here: _____.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. A summary of the Notice will be posted in our office indicating the effective date of the Notice in the upper right hand corner. We will offer you a copy of the Notice on your first visit to us after the effective date of the then current Notice. We will also provide you with a copy of the Notice upon your request.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. **Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the Notice.**