

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by **Advanced Mobility Solutions**. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills. This protected health information may be used or disclosed a third party to advocate on behalf of **Advanced Mobility Solutions** and myself in the resolution of payment/reimbursement issues with the third party payor.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out payment for the services on this consent.

I have the right to revoke this consent, in writing, at any time, except to the extent that **Advanced Mobility Solutions** 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 health care clearinghouse. This protected health information relates to my past, present or futures physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information my identify me.

I understand I have a right to review **Advanced Mobility Solution’s** Notice of Privacy Practices prior to signing this document. 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 the **Advanced Mobility Solutions**. This Notice of Privacy Practices also describes my rights and the **Advanced Mobility Solutions** duties with respect to my protected health information.

Advanced Mobility Solutions 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 calling the office and requesting a revised copy be sent in the mail or asking for one in person.

Signature of Patient or Personal Representative Name of Patient or Personal Representative
(please print name also)

Date

Relationship to patient (or authority to sign)