CONSENT FOR USE OR DISCLOSURE OF PATIENT INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I hereby consent to **Danny L Harrison, MD** (the "Practice") using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out the Practice's health care operations. I also consent to Practice using or disclosing my protected health information for treatment activities provided by another health care provider, as well as the payment activities conducted by another health care provider or entity. I further consent to the disclosure of my protected health information in order for another provider or health care entity to conduct health care operations including quality assessment and reviewing the competence of health care professionals.

Specific Records Expressly Included. I expressly authorize release of the following information for the purposes of treatment, payment and health care operations, if it is part of my protected health information (CHECK ANY OR ALL YOU AGREE TO AUTHORIZE FOR RELEASE):

- **O** Chemical Dependency/Substance Abuse
  - ♦ Drugs
  - ♦ Alcohol
- **O** Sexually Transmitted Diseases

I further acknowledge the Practice has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

MEDICARE & INSURANCE ASSIGNMENT OF BENEFITS SIGNATURE ON FILE

I request that payment of authorized Medicare OR Insurance benefits be made on my behalf to Dr Harrison for any services furnished me. Dr Harrison agrees to accept the charge determination of the Medicare carrier or Insurance Company as the full charge. The patient is responsible for the deductible, coinsurance, and non-covered services at the determination of the Medicare carrier or Insurance Company.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority