Holland Hospital
PHYSICIAN OFFICES

CONSENT FOR THE USE AND DISCLOSURE OF YOUR HEALTH INFORMATION

Our purpose in asking you to sign this form is to document that we have informed you that this office may use and disclose all of your health information in our possession (collectively "Protected Health Information").

The uses and disclosure by this office of your Protected Health Information are necessary and will be used by this office in connection with your treatment, our obtaining payment for treatment and services that this office provides to you, and so that this office can conduct its health care operations.

For a more complete description of how this office may use or disclose your Protected Health Information, please carefully review the Notice of Privacy Practices Form that this office has prepared and is furnishing to you today. Please also see our Notice of Privacy Practices Form for a more detailed discussion of the meanings of "treatment," "payment," and "health care operations."

Lakeshore Health Partners participates in an organized health care arrangement with Brain + Spine Center, PLC, Holland's Bone & Joint Center and Western Michigan Urological Associates. The organized health care arrangements uses an inte- grated electronic medical record system. Participants in this integrated medical record system may use and disclose records for treatment, payment and health care operations purposes relating to their own patients, and as otherwise required by law or permitted by HIPAA, INCLUDING, IF APPLICABLE, ANY INFORMATION IN MY MEDICAL RECORDS RE- LATING TO HIV INFECTION OR ACQUIRED IMMUNODEFICIENCY SYNDROME (HIV/AIDS).

YOU HAVE THE RIGHT TO REVIEW OUR NOTICE OF PRIVACY PRACTICES FORM PRIOR TO SIGNING THIS CONSENT. PLEASE BE ADVISED THAT THE NOTICE OF PRIVACY PRACTICES FORM MAY BE REVISED BY THIS OFFICE FROM TIME TO TIME. ANY SUCH REVISED NOTICE OF PRIVACY PRACTICES WILL BE MADE AVAIL- ABLE TO YOU BY CONTACTING THE OFFICE MANAGER.

YOU SHOULD ALSO REVIEW CAREFULLY THE NOTICE OF PRIVACY PRACTICES FORM BECAUSE IT CONTAINS A LIST OF RIGHTS THAT ARE AVAILABLE TO YOU WITH RESPECT TO THIS OFFICE'S USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION. THESE RIGHTS INCLUDE YOUR RIGHT TO REQUEST RESTRICTIONS ON OUR USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION.

YOU HAVE THE RIGHT TO REVOKE THIS CONSENT AT ANY TIME. IF YOU WISH TO REVOKE THIS CONSENT, YOU MUST DO SO IN WRITING.

BY SIGNING BELOW, YOU ACKNOWLEDGE THAT YOU HAVE READ AND UNDERSTAND THIS CONSENT AND THIS OFFICE'S NOTICE OF PRIVACY PRACTICES FORM. YOU FURTHER ACKNOWLEDGE THAT YOU HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES FORM TO TAKE WITH YOU.

_____	_____
Patient Name	Patient Date of Birth
_____	_____
Patient (Guardian) Signature/Relationship to Patient	Date
_____	_____
Witness	Date