

CEDARS HEALTH, LLC

Consent for Purposes of Treatment, Payment and HealthCare Operations

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1453-A Dewar Drive, Rock Springs, WY, 82901 307.382.2466; 813 Highland Ave, Sheridan
WY 82801 307.673.5501

I consent to the use or disclosure of my protected health information by **CEDARS HEALTH, LLC** for the purpose of diagnosing or providing treatment to me, obtaining payment or to conduct health care operations of **CEDARS HEALTH**. I understand that **CEDARS HEALTH** may request and obtain medical records, pharmacy records and/or dental records in my treatment. I understand diagnosis or treatment of me 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. **CEDARS HEALTH** is not required to agree to the restrictions that I may request. However, if **CEDARS HEALTH** agrees to a restriction that I request, the restriction is binding on **CEDARS HEALTH**.

I have the right to revoke this consent, **in writing**, at any time, except to the extent that **CEDARS HEALTH** 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 healthcare provider, a health plan, my employer, or a healthcare clearing house. This protected 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 **CEDARS HEALTH** Privacy Policy (HIPPA) prior to signing this document. **CEDARS HEALTH** Privacy Policy has been provided to me. The Privacy Policy describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment or in the performance of the health care operations of **CEDARS HEALTH**. The Privacy Policy for **CEDARS HEALTH** is held at the reception desk. This Privacy Policy also describes my rights and **CEDARS HEALTH'S** duties with respect to my protected health information.

CEDARS HEALTH reserves the right to change the privacy practices that are described in the Privacy Policy. I may obtain a revised notice of privacy practices by contacting **CEDARS HEALTH** and requesting a revised copy be sent in the mail or asking the receptionist for a revised copy at my next appointment.

Signature of Patient or Personal Representative

Patient Name and Date of Birth

DATE

Description of Representative