**Paula M. Muto, M.D.**
**Effective 01/14/03**

## Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Paula M. Muto, M.D., for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Paula M. Muto, M.D. I understand that diagnosis or treatment of me by Paula M. Muto, M.D. may be conditioned upon my consent as evidenced by my signature on this document.

I understand that 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 health care options operations of the practice. Paula M. Muto, M.D. is not required to agree to the restrictions that I may request. However, If Paula M. Muto, M.D. agrees to a restriction that I request, the restriction is binding on ______________________________________________________________

_______________________________________________________________________________________________.

I have the right to revoke this consent in writing, at any time, except to the extent that Paula M. Muto, M.D. 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 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 Paula M. Muto, M.D.'s Notice of Privacy Practices prior to signing this document. The Paula M. Muto, M.D.'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 Paula M. Muto, M.D.

Paula M. Muto, M.D. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised copy by calling the office and requesting that a revised copy be sent to me in the mail or by asking for one at the time of my next appointment.

_________________________________________________ _________________________
Signature of Patient or Personal Representative Date

_________________________________________________
Name of Patient or Personal Representative

_________________________________________________
Description of Personal Representative's Authority

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Merrimack Valley Physicians, Inc.
HIPAA Task Force
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