

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Health Care Operations, and the Agency's HIPAA Privacy Policy

The Health Insurance Portability and Accountability Act ("HIPAA") safeguards your privacy by, among other things, restricting who may see or be notified of your protected health information. Protected health information includes, but is not limited to, health records describing your health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. You understand and have been provided with a copy of the HIPAA Privacy Rule (effective April 14, 2003), which provides a more complete description of protected health information uses and disclosures.

As part of your health care, European Expert Care Agency, Inc. (the "Agency") may originate, and will likely maintain, protected health information and other health information about you. The Agency has adopted a HIPAA Privacy Policy to safeguard your protected health information. The Agency's Privacy Policy requires us to: (1) maintain that information in a locked area with in the office; (2) not make your protected health information available to persons other than Agency staff; and (3) keep your protected health information confidential.

The Agency will, however use and disclose your protected health information, and other health information, as is necessary to provide services or to ensure that all administrative matters related to your health care are handled appropriately. Under this Privacy Policy, we will share your protected health information and other health care information with other health care providers, laboratories, and health insurance payers as necessary and appropriate to diagnose and treat you, obtain payment for services rendered to you, and conduct the Agency's health care operations.

You can request restrictions on how your health information may be used or disclosed to carry out treatment, payment, or health care operations. Please note, though, that the Agency is not required to agree to the restrictions requested.

Once executed, this Consent remains in force until revoked. You may revoke this Consent in writing, except to the extent that the Agency has already taken action in reliance thereon.

I, _____, hereby consent to the use, disclosure, and handling of my PHI and other health information for the purposes, and in the manner, described above.

Signature of Patient or Legal Representative* Date:

* If signed by a Legal Representative, describe your legal authority in writing on this Consent. Where a POA is in place, please provide a copy of the POA to the Agency at the time that this Consent is signed.