25751 McBean Parkway
Suite 215
Valencia, CA 91355
Phone (661) 253-3399
Fax (661) 253-3999

# CONSENT TO THE USE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

Tarek Bittar, M.D.
Orthopedic Surgery & Sports Medicine

19950 Rinaldi St.
Suite 101 D
Porter Ranch, Ca. 91326
Phone (818) 256-1948
Fax (661) 253-3999

NAME: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

I understand that as part of my healthcare, Tarek Bittar, M.D. originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. This important information may be used and disclosed for my treatment, so that my provider can get paid and for various uses related to my provider's operations.

**I understand that this information serves as:**

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

**I understand that I have the right:**

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my heath information may be used or disclosed to carry out treatment, payment or healthcare operations - and that Tarek Bittar, M.D. is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that Tarek Bittar, M.D. has already taken action in reliance thereon.

☐ I request the following restrictions to the use or disclosure of my health information:

_____

_____

_____

**PATIENT**

X _____ _____ _____

**Signature of Patient or Legal Representative** **Date:** **Signature of Witness**