TRI-RIVERS HEALTHCARE, PLLC
PRIVACY CONSENT

Tri-Rivers Healthcare, PLLC considers all patients for treatment without regard (i) because the individual is unable to pay; (ii) because payment for those services would be made under Medicare, Medicaid or the Children's Health Insurance Program (CHIP); or (ii) based upon the individual's race, color, sex, national origin, disability, religion, or sexual orientation.

Privacy Consent

I hereby consent to Tri-Rivers Healthcare, P.L.L.C. (the "Practice") using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out the Practice's health care operations. I also consent to Practice using or disclosing my protected health information for treatment activities provided by another health care provider, as well as the payment activities conducted by another health care provider or entity. I further consent to the disclosure of my protected health information in order for another provider or health care entity to conduct health care operations including quality assessment and reviewing the competence of health care professionals.

Specific Records Expressly Included. I expressly authorize release of the following information for the purposes of treatment, payment and health care operations, if it is part of my protected health information (CHECK ANY OR ALL YOU AGREE TO AUTHORIZE FOR RELEASE):

- ❑ Chemical Dependency/Substance Abuse
- ❑ Drugs
- ❑ Alcohol
- ❑ Sexually Transmitted Diseases

I further acknowledge the Practice has provided me a copy of its Notice of Privacy Practices , Financial Agreement and HIV (AIDS) educational information, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information, my financial obligations and information regarding methods of transmission, prevention and appropriate behavior and attitude change regarding HIV (AIDS).

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Signature of Patient or Personal Representative

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Name of Patient or Personal Representative

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Date

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Description of Personal Representative's Authority