

**CONSENT TO USE AND DISCLOSURE OF HEALTH INFORMATION  
FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS**

I understand that as part of my healthcare, the Mountaineer HBPA Benevolent Trust originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, billing and payment records, and

Any plans for future care or treatment, I understand this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health care professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information for payment of my bill
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I hereby consent to the release by the Trust of my healthcare information for the purpose of Carrying out treatment, payment or healthcare operations relating to my healthcare.

I understand that I have the right to object to the use of my healthcare information. I understand that I have the right to request restrictions as to how my health information may be used to disclose to carry out treatment, payment or healthcare operations and that the Trust is not required to agree to the restrictions requested. I understand that my objection to the use of my healthcare information as described to me on this form may result in non-payment of the charges, which will be presented to the Trust. I understand that I may revoke this consent in writing, except to the extent that the Trust has already taken action in reliance thereon.

I acknowledge that I have read the Mountaineer HBPA Benevolent Trust notice of Privacy Practices.

Signature of Patient	OR	Signature of Authorized Representative (Parents sign here for children)
Date		Relationship to Patient