CARLOS G. OTIS HEALTH CARE CENTER, INC.
Doing Business As All of the Following:
Grace Cottage, Grace Cottage Hospital, Grace Cottage Family Health, Messenger Valley Pharmacy

CONSENT AND ACKNOWLEDGMENT

Consent and Agreement to the Use and Disclosure of Health Information For Treatment, Payment or Healthcare Operations

I understand that as part of my care, Grace Cottage ("GC") originates and maintains records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

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

I may be provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures (release of, or access to, your information). I understand that I have the right to review the notice prior to signing this consent. I understand that GC reserves the right to change their notice and practices. However, prior to a material change taking effect, GC will publish an announcement of the change and post the most current document on the web site.

I understand that my records are subject to confidentiality imposed by state and federal regulation and that my records may not be released or disclosed without my written consent unless otherwise provided for in the regulations.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations. I understand that the organization is not required to agree to the restrictions requested, however if GC agrees to the requested restrictions, they are bound by our agreement.

By signing this form, I consent to GC's use and disclosure of protected health information about me for treatment, payment and health care operations. I understand that I may revoke this consent in writing, except to the extent that GC has already taken action based upon my prior consent. I further acknowledge that I have received the Notice of Privacy Practices from GC.

_____
Name of Individual Receiving Services (please print)

_____ _____
Signature of Individual Receiving Services Or Legal Representative *Witness*

_____
Date

Effective: April 14, 2003
Revised: June 28, 2016