

Champlain Valley Orthopedics, PC
1436 Exchange Street
Middlebury, Vermont 05753
Telephone: 802-388-3194 Fax: 802-388-4881

**Consent to Use or Disclose Protected Health Information
For Treatment, Payment and Health Care Operations**

I consent to allow *Champlain Valley Orthopedics, PC* to use or disclose my protected health information for treatment, payment and health care operations.

- Treatment means the provision, coordination, or management of health care and related services by one or more health care providers.
- Payment means the activities undertaken by a health care provider or health plan to obtain or provide reimbursement for the provision of health care.
- Health care operations means conducting quality assessment and improvement activities; reviewing the competence or qualifications of health care professionals; underwriting, premium rating, and other activities related to health insurance contracts; medical reviews; legal services; auditing functions; and business management and general administrative activities of *Champlain Valley Orthopedics, PC*

I consent to allow *Champlain Valley Orthopedics, PC* to disclose my protected health information for treatment activities of another health care provider.

I consent to allow *Champlain Valley Orthopedics, PC* to disclose my protected health information to another covered entity or to another health care provider for the payment activities of the entity that receives the information.

I consent to allow *Champlain Valley Orthopedics, PC* to disclose protected health information to another covered entity for health care operations activities, provided that *Champlain Valley Orthopedics, PC* and the other covered entity has or had a relationship with the below named patient. The disclosure must be for treatment, payment, or health care operations or for the purpose of health care fraud and abuse detection or compliance.

I acknowledge that I have received a copy of *Champlain Valley Orthopedics, PC's* Notice of Privacy.

Name of patient _____

(Please Print)

Signature of Person Authorizing Consent

Relationship to patient

Date _____