Consent to the Use and Disclosure of Health Information

Name: _____

D/O/B: ___/___/___

I understand that as part of my orthopaedic care under the auspices of **Dr. Salil Gupta** and his affiliate staffs (administrative, billing, phone service etc.) the office generates and maintains original medical records inclusive of my medical history, examination (s), test results and all pertinent data relating to my care. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication amongst the various healthcare professionals who are involved in my care and treatment
- A source of information for billing purposes/claim submissions
- A source of proof for third-party payers that services billed were actually provided
- A point of reference for routine healthcare operations to monitor quality of care

I understand and consent to the use of my medical/billing information be used in connection with any other providers of service directly/indirectly involved with my care knowing that this will be done with prudence under mandatory parameters.

I understand that there is no expiration on this document as it will be used for the duration of my orthopaedic care.

X_____ Date: _____
(signature of patient or legal guardian)