



**Hyndman Area Health Center Inc.**  
144 Fifth Avenue P.O. Box 706  
Hyndman, Pennsylvania 15545  
Phone: (814) 842-3206 Fax: (814) 842-9169  
[hyndmanhealth.org](http://hyndmanhealth.org)

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

I hereby consent to the use and disclosure of information in my medical/dental records for treatment, payment and health care operations purposes. I understand that this consent is voluntary. I understand that information in my medical/dental records may be used and disclosed to persons other than Hyndman Area Health Center to carry out their responsibilities in connection with my medical/dental care treatment, in payment for health care services rendered to me and in activities related to health care operations.

Initials: \_\_\_\_\_

I understand that additional information on Hyndman Area Health Center privacy practices related to my medical/dental records is available from the Hyndman Area Health Center comprehensive Notice of Privacy Practices, a copy of which has been made available to me, and which I have read or do not wish to read, prior to signing this consent.

Initials: \_\_\_\_\_

I understand that changes in the Hyndman Area Health Center's privacy practices will result in modifications to the Notice of Privacy Practices and that up-to-date notices will be available at the reception desk of the Hyndman Area Health Center at 144 Fifth Avenue, Hyndman, PA or 112 North Richard Street, Bedford, PA.

Initials: \_\_\_\_\_

I understand that I may request Hyndman Area Health Center to restrict how or to whom my medical/dental records are used or disclosed, but that Hyndman Area Health Center may refuse the restrictions I request. However, if Hyndman Area Health Center agrees to the restrictions, it is bound to them when disclosing information in my medical/dental records.

Initials: \_\_\_\_\_

I understand that I can revoke this consent at any time, by notifying Hyndman Area Health Center in writing, but if I do, it will not have any effect on actions Hyndman Area Health Center took before they received the notification.

Initials: \_\_\_\_\_

I understand that this consent applies to the use and disclosure of information for treatment, payment, or operations only and that Hyndman Area Health Center may decline to provide medical/dental health care services to me if I do not sign it.

Initials: \_\_\_\_\_

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Patient: \_\_\_\_\_

