

**PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH
INFORMATION FOR TREATMENT, PAYMENT, OR
HEALTH CARE OPERATIONS**

1. I understand that as part of my health care, Guam Memorial Hospital Authority originates, records, and maintains health information about me describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment, I understand that this health information may be used or disclosed by Guam Memorial Hospital Authority for treatment, payment, and health care operations. For example, my health information serves as:
 - A basis for planning my care and treatment;
 - A means of communication among the many health professionals who contribute to my care;
 - A source of information for applying my diagnosis and surgical information to my bill;
 - A means by which a third-party payor can verify that services billed were actually provided; and
 - A tool for routine health care operations, such as assessing quality and reviewing the competence of health care professionals.

2. I acknowledge that I have been provided with Guam Memorial Hospital Authority's Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the Notice of Privacy Practices prior to signing this consent. I understand that Guam Memorial Hospital Authority reserves the right to change its Notice of Privacy Practices and prior to implementation will mail a copy of any revised notice to the address I have provided.

3. 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 health care operations, and that Guam Memorial Hospital Authority is not required to agree to the restrictions requested but if it does, it is bound by such restrictions.

4. I understand that I may revoke this consent in writing, except to the extent that Guam Memorial Hospital Authority has already taken action in reliance thereon.

5. By signing this form, I consent to Guam Memorial Hospital Authority's use and disclosure of my health information for treatment, payment, and health care operations.

I request the following restrictions to the use or disclosure of my health information:

Restrictions Accepted

Restrictions Denied

Signature/Title: _____ Date: _____

Signature of Patient or Legal Representative _____ Date: _____

Witness _____ Date: _____

Notice Effective Date: April 14, 2003