



**CONSENT FOR PURPOSES OF TREATMENT, PAYMENT & HEALTHCARE OPERATIONS**

Patient's Name \_\_\_\_\_  
(Please Print)  
VISTA Medical Group Provider \_\_\_\_\_

In connection with the medical services that I am receiving from the above-named physician or physician group, I hereby authorize the above-named physician and/or group to disclose any/or all Protected Health Information (PHI) concerning my medical condition and treatment, including copies of applicable hospital and medical records to:

- A. Any third party payor covering the medical services of the patient
- B. Other health care professionals and institutions involved in the delivery of health care to the patient
- C. The proponent of any legally sufficient subpoena, or in response to a court order
- D. Employees and agents of the practice, to the degree necessary to facilitate the provision of health care services and payment for such services
- E. Pharmacies
- F. Other parties as otherwise required by law

In each case, the practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above. I further understand that I have been given access to physician's privacy notice and that I have had the opportunity to place special restrictions upon the consent hereby given.

**Special Restrictions:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This consent is valid from the date executed for Six (6) years or until revoked in writing by the patient.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date