CONSENT FOR THE USE AND DISCLOSURE

HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, this facility creates and maintains health records describing my health history. I understand that the surgery center may use this information as:

1. a basis for planning my care and treatment;
2. a means of communication among many health professionals who contribute to my care;
3. a means by which third-party payers can verify that services billed were actually provided; and
4. a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I have been provided a Notice of Privacy Practices, which provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that this facility reserves the right to change its notice and practices. If the facility changes the notice, I can obtain a revised copy by asking the administrator. 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 other healthcare operations and that the facility is not required to agree to the restrictions requested. If the facility does agree to such restrictions, however, they must comply with such restrictions. I understand that I may revoke this consent in writing, except to the extent that the facility has already taken action in reliance on it.

HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual can also request that confidential communication, whether telephone communication or correspondence, be directed to an alternate site such as the individual's office.

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

Home Telephone: (____)_____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call back number only

Work Telephone: (____)_____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call back number only

Cellular Phone: (____)_____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call back number only

Written Communication
- ☐ O.K. to mail to any home address
- ☐ O.K. to mail to:_____
  _____
- ☐ O.K. to fax to: (_____)_____

email:_____

I hereby consent to the release of Protected Health Information to the following individual(s) (Example: Family member, friend, etc.). I understand this authorization will in effect until which time it is revoked.

_____Names/Relationship (please print)

_____Names/Relationship (please print)

_____

Signature of patient or patient's representative Date

_____

Printed name of patient's representative Relationship to patient