Associates in General Surgery, A MEDICAL CORPORATION

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PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- ❑ Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- ❑ Obtain payment from third-party payers.
- ❑ Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand your "Notice of Privacy Practices" containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its "Notice of Privacy Practices" from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the "Notice of Privacy Practices."

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

Patient Name_____

Patient Representative:_____Relationship:_____

Signature:_____

Date:_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

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Revised 10/2018

PATIENT CONSENT FORM

AUTHORIZATION TO USE & DISCLOSE HEALTH INFORMATION

I authorize Kent H. Azaren, MD Inc., doing business as **Associates in General Surgery** to use and disclose a copy of the specific health and medical information described below regarding:

Patient Name:_____

Description of the specific information to be used or disclosed:

_____

_____

_____

Person or entity requesting the information

_____

This information is being requested for the following purpose(s):

_____

_____

_____

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

By:_____ Date_____

(Patient)

Or By:_____ Date_____

(Agent for Patient) Title

This authorization expires:_____

(date)

If we are requesting this Authorization from you for our own use and disclosure or to allow another health provider or health plan to disclose health plan to disclose information to us:

- We will provide services or treatment to you even if we have not received a signed authorization;
- You may inspect a copy of the protected health information to be used or disclosed;
- You may refuse to sign this authorization; and
- We must provide you with a copy of the signed authorization

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.

Unless revoked earlier or otherwise indicated , this Authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.