

General Surgical Associates, P.C.

HIPAA

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for General Surgical Associates, P.C., to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). The notice of Privacy Practices provided by General Surgical Associates, P.C., describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent: General Surgical Associates, P.C., reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Privacy Officer, General Surgical Associates, P.C., 215 East Mansion Street, Suite 3E, Marshall, Mi 49068.

With this consent, General Surgical Associates, P.C., may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. General Surgical Associates, P.C., may leave on the voicemail of my home, cellular or alternate telephone number appointment reminder messages.

With this consent, General Surgical Associates, P.C., may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that General Surgical Associates, P.C, restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow General Surgical Associates, P.C., to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, General Surgical Associates, P.C., may decline to provide treatment to me.

_____ **Date**

_____ **Patient / Guardian Signature**

_____ **Patient Date of Birth**

_____ **Printed Name of Patient / Guardian**