Consent for Use and Disclosure of Health Care Information

Patient name:______________________________ Date of birth:____________
SSN:_________________________ Previous name:_____________________

My health information is a private matter. South Sound Surgical Associates (SSSA) has a form that can tell me how SSSA handles my health information. This form is called "Notice of Patient Privacy Practices". If I ask, SSSA will be happy to provide me with the most current "Notice" before I sign this consent. SSSA may update this "Notice" at any time. If I ask, I will get a copy of the most current "Notice". I agree that SSSA may use and disclose my health information to help treat me. I agree that SSSA may use and disclose my information for billing and payment. I also agree to uses and disclosures of my health information to take care of other health care operations. In general, no other uses or disclosure of my health information will occur unless I tell SSSA it's okay. Sometimes the law may allow release of information without my permission. These situations are unusual. One example would be if a patient threatened to hurt someone. I can ask SSSA to further limit the use or disclosure of my health information. SSSA is not required to agree to my request. If SSSA agrees to any part of my request, SSSA would have to follow the agreed limits. I may cancel this consent at any time, by doing one of the following:

A. Signing and dating a revocation form. I may get this form from SSSA; or

B. Writing, signing, and dating a letter to SSSA. The letter must say I cancel my consent to authorize the use and disclosure of my health information for treatment, payment and health care operations.

If I cancel this consent:
- It will be effective except for actions already taken based upon the Consent; and

- SSSA will not have to provide any more health care services to me. I have been given the chance to read a current copy of SSSA's "Notice of Patient Privacy Practices". I agree to allow SSSA to use and disclose my health information to carry out treatment, payment, and health care operations.

______________________________ ______________ ______________
Patient or legally authorized individual signature Date Time

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Relationship to patient if signed on behalf of the patient by parent, legal guardian, personal representative, etc.

Optional addendums to consent:

1. I give consent to SSSA to leave messages that may contain protected health information (PHI) on my telephone answering machine.

______________________________ ______________
Patient or legally authorized individual signature Date

2. I give consent to SSSA to leave messages that may contain protected health information (PHI) with my spouse or significant other.

______________________________ ______________
Patient or legally authorized individual signature Date (rev. 3/24/03)