Bristol Surgical Associates, P.C.

Your privacy is important to us, please complete the following.

Patient Name: ____ ***D.O.B.:*** ____________________

(PLEASE PRINT)

I authorize Bristol Surgical Associates personnel to communicate my healthcare, appointment and/or billing information to the following individuals:

Name: __________________________________ ***Relationship to patient:*** _____________________

Home Phone #: ___________________________ ***Mobile Phone #:*** ___________________________

Name: __________________________________ ***Relationship to patient:*** _____________________

Home Phone #: ___________________________ ***Mobile Phone #:*** ___________________________

Name: __________________________________ ***Relationship to patient:*** _____________________

Home Phone #: ___________________________ ***Mobile Phone #:*** ___________________________

Name: __________________________________ ***Relationship to patient:*** _____________________

Home Phone #: ___________________________ ***Mobile Phone #:*** ___________________________

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history including, symptoms, examination, test results, diagnoses, treatment, and any plans for further care or treatment. I understand that this information serves as a basis for planning my care and treatment, a means of communication among the many health professionals who contribute to my care, a source of information for applying my diagnosis and surgical information to my bill, a means by which a third party payer can verify that services billed were actually provided, and a tool for routine healthcare operation such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Privacy Practices that 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 the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. 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 healthcare operations and that I may revoke this consent in writing, except to the extend that the organization has a already taken action in reliance thereon.

Patient Signature: ____ **Date:** _________________