Arizona Community Surgeons
dba
Southwestern Surgery Associates

New Patient Consent to the Use or Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I, _____, understand that as part of my health care, Southwestern Surgery Associates (SWSA) originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves:

- ° As 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
- ° A tool for routine health care options such as assessing quality

I understand and I have been provided with a Notice of Information Practices that provides a more complete description of information use and disclosures. I understand that I have the following rights and privileges:

- ° The right to review the notice prior to signing this consent
- ° The right to object to the use of my health information for directory purposes
- ° The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

I understand that SWSA is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that SWSA reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.50 of the Code of Federal Regulations. Should SWSA change their notice, they will post a copy of the revised notice:

- ° In their lobby
- ° On their website
- ° Available if requested

I wish to have the following restrictions/inclusions to the use of or the disclosure of my health information:

_____

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures by fax.

I fully understand and accept/decline the terms of this consent.

_____ on _____

Patient's signature or authorized representative — Date

FOR OFFICE USE ONLY

( ) Consent received by _____ on _____

Staff signature — Date

( ) Consent refused by patient _____ on _____

Staff signature — Date