PATIENT PRIVACY NOTICE

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

TREATMENT: Our physicians and staff will use your medical information to give you the best possible care.

HEALTH CARE OPERATIONS: Tulsa Surgical Arts will use this information for appropriate follow-up care, patient
notification, statistical and regulatory requirements.

BILLING PURPOSES: Tulsa Surgical Arts will use your medical information to bill appropriately for your care.

As stated in our Patient Privacy Notice, we cannot disclose to members of your family, your friends, or other acquaintances any protected healthcare information that directly relates to your health care unless we have written permission from you. We request that you designate the individuals with whom we may discuss your protected health information. Other persons calling about your appointment, billing, or direct health care issues will be refused access to this information, unless authorized below.

I give Tulsa Surgical Arts, and its employees, permission to discuss my protected health care information with the following person(s):

Name: _____
Name: _____
Name: _____
Name: _____

I understand that I may modify this permission at any time. Such changes must be in writing to Tulsa Surgical Arts.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I have the right to refuse to sign this authorization. If I do not sign this consent, Tulsa Surgical Arts Physicians may decline to provide treatment. I also have the right to inspect or copy the information to be used or disclosed.

I acknowledge that I have received a copy of this HIPPA policy. I agree to read this document and comply with the terms set forth for services rendered by all employees of Tulsa Surgical Arts.

Date Signed: _____

Patient Name: _____

Patient Signature: _____

Tulsa Surgical Arts
Coordinator: _____