USF Health Endoscopy and Surgery Center Patient Consent to the Use and Disclosure of Health Information For Treatment, Payment, or Healthcare Operations, per HIPAA Regulations

I understand that as part of my health care, the practice originates and maintains paper and/or electronic records describing my health history, symptoms, examination, and test results, diagnoses, treatments, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the health professionals who contribute to my care, such as referrals
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually rendered
- A tool for routine health care operations, such as assessing quality and reviewing the competence of staff

I have been given the "Notice of Patient Privacy Practices" that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the "Notice" prior to acknowledging this consent
- The right to restrict or revoke the use or disclosure of my health information for other uses or 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.

PLEASE PRINT

Restrictions: I request the following restrictions to the use or disclosure of my health information: Please indicate below (by name and relationship), the persons with whom we may discuss your protected health information:	
Messages or appointment reminders:	
May leave a message at your home using your do	<u> </u>
May leave a message at your work using your doctor's/practice name: ☐ Yes ☐ No Messages will be of non-sensitive nature, such as, appointment reminders.	
	or health care operations, it may become necessary to , referrals to other health care providers. I consent to such the one) the information in this consent.
Patient/Guardian Signature	Date
Printed Name of Signer	
If other than the patient,	signing, because I am the legal guardian,
custodian or have Power of Attorney for this pati	ent, for treatment, payment, or health care operations.
**************	**************
FOR OFFICE USE ONLY	
☐ Consent form received and reviewed by	on
☐ Consent form signature refused by patient	
☐ Patient unable to sign consent form, reason:	