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 doctor's/practice name: □ Yes □ No
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.

I understand that as part of treatment, payment, or health care operations, it may become necessary to disclose health information to another entity, i.e., referrals to other health care providers. I consent to such disclosure for these uses as permitted by law.
I fully understand and accept/decline (please circle 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 patient, for treatment, payment, or health care operations.

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FOR OFFICE USE ONLY
□ Consent form received and reviewed by _____ on _____
□ Consent form signature refused by patient
□ Patient unable to sign consent form, reason: _____