3401 SPRINGHILL DRIVE, SUITE 400
NORTH LITTLE ROCK, AR 72117

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Health Care Operations

I understand that as part of my health care, this organization originates and maintains health records describing my demographic information, health history, symptoms, examination and test results, diagnoses, treatment, 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 many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means to provide for reimbursement from my health insurance company, with transmission of necessary health information via electronic media
- a means by which a third-party payer can verify that services billed were actually provided
- a source of information for consideration of inclusion in clinical research studies
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I understand that I may receive artificial, prerecorded, or automated calls and or/texts from Pulaski Surgery Clinic.

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 health care operations and that the organization is not required to agree to the restrictions requested. I understand that this consent may be revoked with a written notice from me or my legal representative. The revocation will not apply to any past disclosures (for the purposes of treatment, payment, health care operations, clinical research activity, or other mandatory disclosures) that the organization has already disclosed based on my previous consent.

☐ I request the following restrictions to the use or disclosure of my health information.

_____

We will not discuss any aspect of your protected health information with anyone other than yourself without your written consent. If you wish for us to share any of your health information with persons (other than yourself), please list them below and their relationship to you:

_____ _____

Name Relationship to Patient

I have received a copy of the *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I have been given the right to review the notice prior to signing this consent. I understand that this clinic reserves the right to change their notice and practices. I may call the clinic at any time to request a current copy of the privacy practices.

_____ _____

Name (Printed) **Date**

_____ _____

Signature of Patient or Legal Representative **Authority to Consent**

_____ _____

Witness (Pulaski Surgery, P.A. Staff) *Date*

Approved: April 2003 Revision: March 2014