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Houman Solomon, M.S., M.D., FASMBS, FACS
Aileen M. Takahashi, M.D., FACS

Patient Consent Form (Must Be Completed and Returned By Patient Prior To Treatment)

To the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, ___________________________________, (Account Number:_________________________________) understand that as part of my health care, the Association of South Bay Surgeons 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:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare 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 healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a **Notice of Information 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 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 healthcare operations.

Health Information Exchange (HIE):

I understand that Association of South Bay Surgeons may make my individual health information available to a sponsored Health Information Exchange (HIE) and to a regional and or National Health Information Exchange.

I understand that the Association of South Bay Surgeons 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 and/or revoking this consent, this organization may refuse to treat me as permitted by Section 164.520 of the Code of Federal Regulations. Should the Association of South Bay Surgeons change their notice, they will send a copy of any revised notice to the address I've provided (whether US mail or, if I agree, email).

I understand that as part of this organization's treatment, payment, or healthcare 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 via fax.

Can confidential messages be left on your answering machine or voicemail? [ ] YES [ ] NO

Please list, if any, person(s) whom we may inform about your medical condition, diagnosis, and/or financial account:
Name:____ Phone Number:____
Name:____ Phone Number:____
Name:____ Phone Number:____

I wish to have the following restrictions to the use or disclosure of my health Information:____
____
____

(If more space is needed please write on the back.) I fully understand and [ ] accept [ ] decline the terms of this consent.

Patients Signature:____Date: ____
____

FOR OFFICE USE ONLY
[ ] Consent received by____Date:____
[ ] Consent refused by patient, and treatment refused as permitted.
[ ] Consent added to the patient's medical record on (Date)____

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