SURGICAL ASSOCIATES, P.A.

PATIENT CONSENT FOR SURGICAL ASSOCIATES, PA AND DISCLOSURE OF PROTECTED HEALTH INFORMATION AND RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby give my consent for Surgical Associates, PA to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Surgical Associates, PA reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to The Privacy Officer at 200 Banning Street, Suite 200, Dover DE 19904.

With this consent, Surgical Associates, PA may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Surgical Associates, PA may mail to my home or other alternative locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, Surgical Associates, PA may use secure internet communications to communicate with me and assist the practice in carrying out TPO.

I have the right to request that Surgical Associates, PA restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Surgical Associates, PA the use and disclosure of my PHI to carry out TPO and to acknowledge that I have received a copy of Surgical Associates, PA's Notice of Privacy Practices.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Surgical Associates, PA my decline to provide treatment to me.

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Signature of Patient or Legal Guardian Patient's Name Date

_____ _____

Print Name of Patient or Legal Guardian Email address (optional)