



**CONSENT FOR USE OR DISCLOSURE OF
 PERSONAL HEALTH INFORMATION (PHI)**

Use and Disclosure Of Your PHI

Your PHI will be used by the Center of Advanced Pelvic Surgery, or disclosed to others, for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice Of Privacy Practices

You should review our Notice of Privacy Practices for a more complete description of how your health information may be used or disclosed. A copy of this notice will be provided to you upon your request.

Requesting A Restriction On the Use Or Disclosure Of Your Information

You may request a restriction on the use or disclosure of your protected health information. The Center of Advanced Pelvic Surgery may or may not agree to restrict the use or disclosure of your PHI.

If the Center of Advanced Pelvic Surgery agrees to your request, the restriction will be binding on the practice as a whole. Unauthorized use and disclosure of protected information is a violation of an agreed upon restriction, and will be a violation of federal privacy standards.

I give my consent to be contacted in the following manner (please circle Y for Yes or N for No in each instance):

	Home	Work	Cell
It's OK to contact me at:	Y / N	Y / N	Y / N
It's OK to leave a basic message at:	Y / N	Y / N	Y / N
It's OK to leave a detailed message at:	Y / N	Y / N	Y / N

Please list people we may speak to other than you:

Revocation Of Consent

You may never revoke this consent to use and disclosure of your PHI at any time. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation Of Right To Change Privacy Practices

The Center of Advanced Pelvic Surgery reserves the right to modify the privacy practices outlined in this notice.

Signature

I have reviewed this consent form and hereby give my permission to the Center of Advanced Pelvic Surgery to use and disclose my PHI in accordance with these guidelines.

Patient Name _____

Signature of Patient or Patient Representative _____ Date _____