Northeast Alabama Surgical Associates
Urquhart Plastic Surgery

Consent for Purposes of Treatment, Payment, and Health Care Operations

I consent to the use or disclosure of my protected health information by Northeast Alabama Surgical Associates and/or Urquhart Plastic Surgery for the purpose of diagnosing or providing treatment to me, obtaining payment of my health care bills or to conduct health care operations of Northeast Alabama Surgical Associates and/or Urquhart Plastic Surgery. My "protected health information" means medical, billing, and demographic information about me collected from me and created or received by Northeast Alabama Surgical Associates and/or Urquhart Plastic Surgery for treatment, payment, and healthcare operations. I understand that diagnosis or treatment of me by Northeast Alabama Surgical Associates and/or Urquhart Plastic Surgery may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operation of the practice. Northeast Alabama Surgical Associates and/or Urquhart Plastic Surgery are not required to agree to the restrictions that I may request. However, if Northeast Alabama Surgical Associates and/or Urquhart Plastic Surgery agree to a restriction I request, the restriction is binding on Northeast Alabama Surgical Associates and/or Urquhart Plastic Surgery.

I have the right to revoke this consent, in writing, at any time. The revocation will be effective upon receipt, except to the extent that Northeast Alabama Surgical Associates and/or Urquhart Plastic Surgery has taken action in reliance on this consent.

I understand I have a right to review Northeast Alabama Surgical Associates and/or Urquhart Plastic Surgery's Notice of Privacy Practices prior to signing this document. Northeast Alabama Surgical Associates and/or Urquhart Plastic Surgery's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operation of Northeast Alabama Surgical Associates and/or Urquhart Plastic Surgery. The Notice of Privacy Practices for Northeast Alabama Surgical Associates and/or Urquhart Plastic Surgery is also provided in various locations of the facility, to include the waiting room. The Notice of Privacy Practices also describes my rights and Northeast Alabama Surgical Associates and/or Urquhart Plastic Surgery's duties with respect to my protected health information.

Northeast Alabama Surgical Associates and/or Urquhart Plastic Surgery reserve the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

_____ _____

Print Name of Patient Signature of Patient

_____

Date

Names of persons we may communicate with:

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Preferred Phone Number (choose one): ☐ Home ☐ Cell

Communication Preferences (check all that apply): ☐ Voice ☐ Text ☐ Email

☐ Do NOT mail reminder cards **☐ Do leave messages on voice mail/answering machine**

☐ Do leave messages with persons who answer