NOTICE OF PRIVACY PRACTICES
PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclose by us in any form, whether electronically, on paper, orally, are kept confidential.

With my consent, Star Surgical Suites may 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 and at any time in the future by request to Star Surgical Suites.

With my consent, Star Surgical Suites, or employee's of, may call my home or other designated location and leave a message on a 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.

I have the right to request that Star Surgical Suites, 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.

I may revoke my consent in writing, except to the extent that the practice has already made disclosures and reliance upon my prior consent. If I do not sign the consent, Star Surgical Suites, may decline to provide treatment to me.

Signature of Patient: _____ **Date:** _____

Print Name of Patient: _____

Legal Guardian's Name: _____