DAYTIME OUTPATIENT SURGERY CENTER

HIPPA Patient Information Form

I acknowledge I have been given an opportunity to read Daytime Outpatient Surgery Center Privacy Practices. I give my consent to release personal information for the purposes of treatment, referrals, payment or healthcare operations and understand that I may withdraw this consent at any time in writing.

I understand that my medical records may be transmitted electronically by fax and may be received in error by a third party. In the event that this should occur, I absolve Daytime Outpatient Surgery Center of all liability. I give my consent to fax my records for the purposes of treatment, payment, or healthcare operations and understand that I may withdraw this consent at any time in writing.

I also understand that I have the right to request restrictions as to how my health information may be used or disclosed.

I understand that I have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Other person(s) permitted to receive my medical records other than listed in paragraph one:

- ☐ No restrictions – may release information if requested to anyone
- ☐ Restrictions: list who we may release information to regarding your healthcare

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I wish to be contacted in the following manner (Check all that apply):

Home telephone: ____________________________ Cell: _____________________________

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call back number only

Work Telephone number: ___________________________

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call back number only

<u>Pharmacy information</u>

Name: Location Telephone #

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Signature of Patient or Personal Representative Date

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Relationship if other than patient