

Individual Consent/Authorization for the Uses/Disclosures of Protected Health Information

Patient Name:	Medical Record No.:
Description of Information to be used / disclosed: MEDICAL RECORDS	
Person(s) or class of persons authorized to use / disclose the information: FACULTY, STAFF AND/OR PHYSICIANS	
Person(s) or class of persons for or to whom the information may be used or disclosed: OTHER FACULTIES, PHYSICIAN'S OFFICE, HOSPITAL	
Purpose for the use of disclosure: PATIENT CARE	
The information used or disclosed pursuant to this authorization:	
<p>General Consent to Use / Disclose Medical Information</p>	
<p>Our Notice of Privacy Practices, receipt of which you acknowledge by signing this Consent, provides information about how we may use and disclose medical information about you. You have the right to review our notice before signing this consent. As provided for in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting us at the address noted below.</p>	
<p>You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or practice operations. You may also restrict the information that is made available to the public. We are not required to agree with a restriction, but if we do, we are bound by our agreement.</p>	
<p>By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and practice operations as described in our notice. You have the right to revoke this consent, in writing, except where we have already made disclosures or used your information in reliance on your prior consent.</p>	
<p>Consent Related to HIV / AIDS</p>	
<p>The information we use or disclose, as described in our Notice of Privacy Practices, may include information about Acquired Immunodeficiency Syndrome (AIDS), AIDS-related complex, or tests for or infection with the Human Immunodeficiency Virus (HIV). You consent to the use or disclosure of this health information for treatment, payment, or practice operations as described in our Notice.</p>	
<p>Consent Relating to Mental Health and Substance Abuse Information</p>	
<p>The information we use or disclose as described in our Notice of Privacy Practices may contain information regarding psychiatric conditions, alcohol or substance abuse. You consent to the use or disclosure of this health information for treatment, payment, or practice operations as described in our Notice.</p>	

Expiration

Important Notice

This authorization (check one):

- Does not expire.
- Expires on ____/____/____.
- Expires upon the occurrence of the following described expiration event: _____

You have the right to revoke this authorization. Your revocation must be in writing and addressed to:

Susan Donigan, Privacy Officer
 Surgery Center of Volusia, LLC.
 3635 Clyde Morris Blvd., Ste. 500
 Port Orange, FL. 32129
 (386) 760-8151

We will not condition the provision of health care whether you sign this authorization. The authorization is needed to provide information relating to health care and to provide health information to a third party.

The information used or disclosed pursuant to this authorization may be re-disclosed by the recipient of the information and may no longer be protected by applicable law or regulations.

Inquiries regarding our privacy practices should be directed to the Privacy Officer at the address or phone number listed above.

You have the right to a copy of the signed authorization, if the authorization is being made at our request.

I consent to the use or disclosure of my medical information as described above.

Signature (Patient or Representative): _____

Date: ____/____/____

Relationship, if not Patient: _____

Patient is unable to sign because: _____

Witness: _____

Date: ____/____/____