PRINCETON SURGICAL ASSOCIATES, P.A.

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Patient Authorization for Disclosure of Protected Health Information

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 controls how the Protected health Information (PHI) of our patients can be discussed and with whom. This form authorizes the doctors and staff of Princeton Surgical Associates, PA to discuss your PHI with those you have listed below and in what specific manner.

Individuals to whom your health information may be disclosed (please check all that applies):

	Spouse Name		Phone Number	
	Parent Name		Phone Number	
	Child Name		Phone Number	
	Other Name		Phone Number	
	Other Name		Phone Number	

Can the doctors and employees of Princeton Surgical Associates, PA leave messages on your answering machine? _____At Home _____At Work _____Cell Phone

What kinds of information can be disclosed?

_____	All-at the Doctors discretion	Medical History	_____
_____	Tests Ordered/ Test Results	Surgery/ Scheduling Information	_____
_____	Diagnosis	Billing/ Insurance Information	_____
_____	Treatment	Other	_____
_____	Only a Return Call Message		

The patient has the right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization. This authorization will remain in effect unless otherwise revoked by the patient. Release of the Protected Health Information covered by this authorization will be disclosed solely for the purpose of keeping designated family members informed of your healthcare condition.

Patient Name | Social Security Number | Date of Birth

Patient Signature | Date

Last reviewed: 9.5.14
Patient Hippa.Doc

Patient Consent to the Use and Disclosure of Health Information
For Treatment, Payment, or Healthcare Operations

I understand that as part of my health care, Princeton Surgical Associates, PA originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Princeton Surgical Associates, PA is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I further understand that Princeton Surgical Associates, PA reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Princeton Surgical Associates, PA change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail of, if I agree, email).

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.