EASTSIDE SURGICAL ASSOCIATES, PLLC
SAM M. SALAMA, MD FACS

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for EASTSIDE SURGICAL ASSOCIATES to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations. (The Notice of Privacy Practices provided by EASTSIDE SURGICAL ASSOCIATES describes such uses and disclosures more completely and is continually posted on the wall in the waiting room at EASTSIDE SURGICAL ASSOCIATES.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. EASTSIDE SURGICAL ASSOCIATES reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Suzanne Crook at EASTSIDE SURGICAL ASSOCIATES.

With this consent, EASTSIDE SURGICAL ASSOCIATES may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, EASTSIDE SURGICAL ASSOCIATES may mail to my home or other alternative location any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminder cards and patient statements."

With this consent, EASTSIDE SURGICAL ASSOCIATES may e-mail to my home or other alternative location any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminder cards and patient statements. I have the right to request that EASTSIDE SURGICAL ASSOCIATES restrict how it uses or discloses my PHI to carry out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

In addition EASTSIDE SURGICAL ASSOCIATES keeps a record of your health care service we provide you. You may ask to see and receive a copy of that record. (There may be charges for copying your record.) You may also ask us to correct that record. You may see your records, or receive more information about it by contacting our medical staff.

By signing this form, I am consenting to allow EASTSIDE SURGICAL ASSOCIATES to use and disclose my PHI to carry out treatment, payment, and health care operations. I also acknowledge receipt of the Notice Of Privacy Practices.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, EASTSIDE SURGICAL ASSOCIATES may decline to provide treatment to me.

Signature of Patient or Legal Guardian	Date	Relationship to Patient

Print Patient's Name	Print Name of Legal Guardian, if applicable

Patient/guardian must be provided with a signed copy of this authorization form.

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