PRESIDIO
surgical group, pc

Patient Consent for use and disclosure of protected health information and acknowledgement of receipt of privacy notice as required by the privacy regulations created as a result of the health insurance portability and accountability act of 1996 (HIPAA).

With my consent, Presidio Surgical Group, P.C. (PSG) may use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment and healthcare Operations (TPO). Please refer to PSG's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. PSG reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to our Privacy Office at PSG, 6320 N. La Cholla Blvd., Suite 310, Tucson, Arizona 85741, With my consent, PSG may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal or Confidential.

I have the right to request that PSG 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.

By signing this form, I am consenting to PSG's use and disclosure of my PHI to carry out TPO. 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, PSG may decline to provide treatment to me.

Note: Quality healthcare is partnership between patient and physician. Should you require further testing, imaging studies or return visits to monitor your well-being, you must assume responsibility of following through. If for some reason you do not agree with the test requested, please show us the courtesy of communicating this concern.

_____ _____

Print Name of Patient or Legal Guardian | Date

_____ _____

Signature of Patient or Legal Guardian | Name of Patient (if different)

Acknowledgement of receipt of privacy notice

I acknowledge that I have received a copy of the office's Notice of Privacy Policies

_____ _____

Patient or legal authorized signature | Relationship to Patient