SCOT D. PARIS, MD, FACS

PATIENT CONSENT FORM

By signing this form, you are giving Pottstown Surgical Associates consent to use and disclose your protected health information for the purposes of treatment, payment and healthcare operations. Your protected health information will not be disclosed to any other person or entity without your written permission.

Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent. We encourage you to read it in full. A complete copy is located at 1329 East High Street, Suite 1 Pottstown, PA 19464. You may have a copy if you request one. Our Notice of Privacy Practices is subject to change. Any revisions will be posted in the reception area of our office.

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or healthcare operations. We are not required by law to grant your request. You have the right to not sign this authorization and that your refusal will not affect your ability to obtain treatment from us. However, we will use your information to obtain payment.

You have the right to revoke this consent in writing, except to the extent we have already used or disclosed your protected health information in reliance on your consent.

Please list any individuals to whom we may release information about your medical care.

NAME:_____ RELATIONSHIP:_____

NAME:_____ RELATIONSHIP:_____

NAME:_____ RELATIONSHIP:_____

SIGNATURE:_____ DATE:_____