

River Walk Surgical Associates

Patient Consent Form For Protected Health Information

By signing this form, you give your consent to our use and disclosure of protected health information about you for our treatment, payment and health care operations purposes. Federal law requires that we obtain a written consent of this kind from you for those uses and disclosures. If we use or disclose your protected health information for any other purposes, we must obtain a separate written authorization from you with details about the proposed use or disclosure.

Our Notice of Privacy Practices provides more detailed information about how we may use and disclose protected health information about you. You have the right to review that Notice before signing this consent. We reserve the right to change the Notice, and if we do, you may obtain a copy of the revised Notice from:

River Walk Surgical Associates
Attention: Medical Records
9300 Stockdale Hwy, Ste 300
Bakersfield, CA 93311

Once you give us this consent, we can rely on it until you revoke it. You can revoke it by delivering a dated and signed letter to River Walk Surgical Associates at the location above. However, we may choose not to treat you if you revoke your consent.

You may also request that we restrict how we use or disclose protected health information about you, by making the request in a dated and signed letter delivered to River Walk Surgical Associates at the location above. (A form for such a request is available from the same office.) We are not required to agree to those restrictions, but if we do, we will be bound to comply with that agreement.

X _____
Signature (Patient or Legal Representative)

Printed Patient Name

Date

Capacity of Legal Representative (if applicable)