Consent for Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Surgical Associates of Central Florida, P.A. (hereafter referred to as Surgical Associates) for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct healthcare operations. I understand that diagnosis or treatment of me by the doctors of Surgical Associates may be rendered based on upon my consent, as evidenced by my signature below.

The Notice of Privacy Practices has been made available to me and I understand that I have the right to review it prior to signing this consent. Surgical Associates reserves the right to modify the Notice of Privacy Practices. Please refer to the Notice of Privacy Practices for additional information regarding your privacy rights.

I ____________________________________, am also giving Surgical Associates of Central Florida, PA permission to involve the below listed people in my complete medical care.

I understand and give my permission to Surgical Associates of Central Florida, PA to discuss testing, treatment, and any results with the below people for the purpose of my medical care and wellbeing.

This permission also includes any and all financial issues involving my account and further care.

I understand that this permission will remain in place until I request a change.

Persons Name:__________________________________ Relationship:______________________
Phone Number:__________________________________ Circle one: **cell home work**

Persons Name:__________________________________ Relationship:______________________
Phone Number:__________________________________ Circle one: **cell home work**

Persons Name:__________________________________ Relationship:______________________
Phone Number:__________________________________ Circle one: **cell home work**

Patient Signature:____ Date:_________________________
Print Patient Name:____