Image Guided Surgery
The Fibroid and Vascular Experts

HIPAA PATIENT CONSENT FORM

I understand that I have certain Rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA): I understand that by signing this consent, I authorize Image Guided Surgery to use and disclose my protected health information (PHI) to carry out the following:

- Treatment (including direct and indirect treatment by others healthcare providers involved in my treatment);
- Obtaining payment from third party payers (i.e. my insurance company)
- The day-to-day healthcare operations of Image Guided Surgery

I have also been informed of, and given the right to review and secure a copy of the Image Guided Surgery Privacy Statement, which contain a more complete description of the uses and disclosures of my PHI and my rights under HIPAA. I understand that Image Guided Surgery reserves the right to change the terms of this notice at any time and that I may contact Image Guided Surgery at any time to obtain the most current copy of this notice.

I understand that I may revoke this consent at any time. However, any use or disclosure that occurred prior to the revocation date as not affected.

Patient Signature: _____ Date: _____

CONTACT CONSENT

I wish to be contacted in the following manner, including automated appointment reminders (check all that apply), be sure to fill in phone numbers.

____ Home Telephone # _____ (Can leave a message with detailed information? Yes/No_____ Leave a message with a call back number only? Yes/No _____)

____ Work Telephone # _____ (Can leave a message with detailed information? Yes/No_____ Leave a message with a call back number only? Yes/No _____)

____ Written Communication _____ (Okay to mail to my home address Yes/No ___ Okay to EMAIL: _____Yes/No Okay to fax to this number(s) _____ Yes/No)

Other Requests: _____