# CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

The physicians of Ambulatory Medical Anesthesia Services, INC. (“Anesthesia Group”) provide anesthesia services at Ambulatory Surgery Center of Western New York Surgery Center. By signing this consent form, you agree to allow both Anesthesia Group and the surgery center to use your individually identifiable health information for the purposes described below. You also acknowledge that you have received the notice that describes the privacy practices of both Anesthesia Group and the surgery center. The surgery center and Anesthesia Group have developed a joint notice of their privacy practices and are using this joint consent form in order to simply the administrative process for patients. However, Anesthesia Group and the surgery center are separate legal entities. They are each separately required to comply with state and federal law. They must each comply with the notice and this consent form. The surgery center and Anesthesia Group are not responsible for the other’s failure to comply with the notice or this consent form.

I understand that as part of my healthcare, the surgery center and Anesthesia Group create and maintain health records describing my health history. I understand that the surgery center and Anesthesia Group may use this information as:

1. a basis for planning my care and treatment;
2. a means of communication among many health professionals who contribute to my care;
3. a means by which third-party payers can verify that services billed were actually provided; and
4. a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I hereby consent to the surgery center’s and Anesthesia Group’s use and disclosure of my individually identifiable health information for the purposes listed above and other purposes relating to my treatment, the payment of my health care, and other health care operations of the surgery center and Anesthesia Group. In addition, I acknowledge that I received on the date indicated below a copy of the Ambulatory Surgery Center of Western New York & Ambulatory Medical Anesthesia Services. Notice of Privacy Practices, which describes the obligations of the surgery center and Anesthesia Group regarding their use and disclosure of my individually identifiable health information and my rights regarding this information. I also understand that the surgery center and Anesthesia Group reserve the right to change their notice and practices. If the surgery center and Anesthesia Group change the notice, I can obtain a revised copy by asking the administrator of the surgery center. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or other healthcare operations and that the surgery center and Anesthesia Group are not required to agree to the restrictions requested. If the surgery center or Anesthesia Group do agree to such restrictions, however, they must comply with such restrictions.

_____ I request the following restrictions to the use or disclosure of my health information.

______________________________________________________________

Effective Date of Notice:________

I give my permission for a phone message to be left in regards to my follow up care.

☐ Yes ☐ No

Signature___________________________________ Date________________

You may speak with____________________________ at this number___________________

Relationship to patient:____________________________________________