CONSENT TO TREAT, CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION, AND ACKNOWLEDGEMENT OR RECEIPT OF NOTICE OF PRIVACY PRACTICES

1. **Patient Consent to Treat**

   I, the undersigned patient, consent to the administration of anesthesia and related procedures and/or procedures performed at Unifour Pain Treatment Center as are deemed necessary by the anesthesia provider, including those which are in addition to or different from those initially contemplated, which anesthesia and procedures are deemed necessary or advisable by the anesthesia provider in the course of anesthesia administration, the surgery, or procedure.

2. **Patient Consent for Use and Disclosure of Protected Health Information ("PHI")**

   I, the undersigned patient, give my consent to the provider, its anesthesia group, and their agents to use or disclose my protected health information ("PHI") to carry out treatment, payment, or health care operations. These individuals and entities can release, use, or disclose my PHI to other physicians, certified registered nurse anesthetists, anesthesia assistants, anesthesia staff, nursing staff, nurse practitioners, physician assistants, child life specialists, respiratory therapists, X-ray personnel, audiologists, students in each of the above disciplines, and other such entities or persons as are deemed related to treatment, payment, and health care operations, as determined in the sole discretion of the provider, his/her anesthesia group and their respective agents.

3. **Permission to Release Medical Record to Providers**

   If another provider who is involved with treatment, payment, or health care operations relating to me requests my medical records, I consent to the release of my entire medical record maintained by the provider to those other providers.

4. **Permission to Release Billing Information Over the Telephone**

   I agree, as part of this consent for payment operations, that the provider, its group, and their billing personnel, billing agents, or management company can disclose billing information to any person that calls the provider with billing questions after the provider inquires as to the identity of the calling person and the calling person provides my correct social security number o health plan number.

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5. **Permission to Call and Leave Voice Mail Messages**

I agree that the provider or its agents or representatives may call and leave a voicemail message at my home or other number I provide them regarding medical appointments, billing or payment issues, or other information related to treatment, payment, or health care operations.

6. **Permission to Discuss Protected Health Information with Third Persons**

I agree that the provider may discuss my PHI with any person that accompanies me to a visit or procedure or is present with me when the provider is present. The provider may rightly assume that is another person is with me, I have no objection to disclosure of my PHI to that person. I also agree the provider may discuss my PHI with any person that identifies him or herself as active in my mental, physical, emotional, or spiritual care, including, but not limited to family, friends, clergy, and patient advocates. I also agree that the provider, his/her anesthesia group, and their agents may disclose my PHI to employers who arrange and pay, directly or indirectly, for my medical treatment.

7. **Permission to Discuss Protected Health Information Regarding Minors**

I agree that the provider, his/her anesthesia group, and their agents may discuss my child's PHI with the person accompanying the child. I agree that the provider may discuss PHI with both natural parents and stepparents. I acknowledge that state law may grant my child certain privacy rights regarding the child's PHI, and that I have no right to receive this information.

8. **Permission to Discuss Protected Health Information with Public Agencies**

I agree the provider, his/her anesthesia group, and their agents may, upon request by the following entities, disclose my PHI to public health agencies, law enforcement and the FDA.

9. **Acknowledgment of Receipt of Notice of Privacy Practices**

I acknowledge that I have received from this provider a copy of a separate document, entitled, "Notice of Privacy Practices" which sets forth this provider's privacy practices and my rights regarding privacy of my PHI.

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PATIENT SIGNATURE **DATE**
Or Personal Representative

NAME OF ENTITY: Unifour Anesthesia Associates, PA

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