VEGA SURGICAL GROUP

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HIPPA PRIVACY RULES

Acknowledgement of Receipt of Notice of Privacy Practices

I understand that as part of my healthcare, this facility creates and maintains health records and other information describing my health history, symptoms, examination and test results, diagnosis, treatment, plans for future care or treatment, and other information. I acknowledge that I have been provided with a copy of this facility's Notice of Privacy Practices and understand that this facility's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that:

1. I have the right and have been given the opportunity to review this facility's Notice of Privacy Practices prior to signing this acknowledgement.
2. This facility reserves the right to change their Notice of Privacy Practices and that prior to the implementation of any such change will mail a copy of any revised notice to the address I have provided if requested.

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations

I understand that:

1. I have the right to review this facility's Notice of Privacy Practices prior to signing this consent;
2. This facility reserves the right to change the notice and practices and that prior to implementation will mail me a copy of any revised notice if requested;
3. I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this facility is not required by law to agree to the restrictions requested.
4. I may revoke this consent in writing at any time, except to the extent that this facility, has already taken action in reliance thereon.
5. It is this facility's procedure to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

By signing this form, I consent to the use and disclosure of my PHI for the purposes of treatment, payment, health care operations, and other categories listed in this notice. I understand that I may revoke this consent, in writing, except where such disclosures have already been made in reliance on my prior consent.

Release of Protected Health Information to Authorized Parties

Notwithstanding the confidentiality of my protected health information, I hereby authorize the following individuals to discuss and have access to my protected health information.

□ I elect not to designate any individuals who may discuss or access my protected health information.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

My consent to this Notice of HIPAA Privacy Rules is given freely with the understanding that:

1. Any and all records, whether written, oral, or electronic, are confidential and cannot be disclosed for reasons stated outside the notice without my prior written authorization, except as otherwise provided by law;
2. A photocopy or fax of this consent is as valid as the original; and
3. I have the right to request that the use of my PHI, which is used or disclosed for the purposes of treatment, payment, health care operations, and other categories listed in the Notice be restricted. I also understand that Lixana Vega Vega, MD, PLLC, d/b/a Vega Surgical Group PLLC, and I must agree to any restriction in writing that I request on the use and disclosure of my PHI and agree to terminate, in writing, any such restrictions on the use and disclosure of my PHI which have been previously agreed upon.

_____ _____
Printed Name of Patient or Legal Guardian/ Representative Date

X_____ _____
Signature of Patient or Legal Guardian Representative Relationship to Patient, if Signed by Legal Guardian