

**LUTHERVILLE SURGICENTER
PATIENT CONSENT
USES AND DISCLOSES REQUIRING AN OPPORTUNITY FOR THE INDIVIDUAL
TO AGREE OR OBJECT**

Patient's Name: _____ Date: _____

Patient's Social Security Number: _____ Date of Birth: _____

By signing this form, I consent to LSC's use and disclosure of my Protected Health Information for the purposes of *treatment, payment and/or health care operations* as defined in the Privacy Notice of LSC.

Signature of Patient or Legal Representative

Witness

I acknowledge receipt of the Notice of Privacy Practices. _____
Patient's Initials

CONTACT INFORMATION

1) HOW SHOULD WE CONTACT YOU?

You have the right to request us to contact you in a certain way or at a certain place. Please let us know if you have a contact preference, e.g. cell phone, home, work:

2) TO WHOM MAY WE DISCLOSE (Person to whom LSC MAY USE OR DISCLOSE PHI*)

Name: _____

Relationship to patient: _____

Address: _____ Home Tel: _____

_____ Work Tel: _____

Other contact information, e.g. cell phone _____

3) TO WHOM MAY WE NOT DISCLOSE (Person to whom LSC MAY NOT USE OR DISCLOSE PHI*)

Name: _____

Relationship to patient: _____