Patient Consent for the use and Disclosure of Protected Health Information
Douglas Vascular Center

With my consent, Douglas Vascular Center may use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). Please refer to Douglas Vascular Center Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent.

I understand that Douglas Vascular Center reserves the right to revise its Notice of Privacy Practices in accordance with Section 164.520 of the Code of Federal Regulations. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Privacy Officer, Douglas Vascular Center, 326 Shirley Avenue, Douglas, GA 31533.

As a patient, you have a right to inspect copy, amend, request a restriction or revoke a prior restriction on the use and disclosure of your Protected Health Information (PHI). You may also request a copy of an accounting of disclosures, which will detail all disclosures made for reasons other than treatment, payment, or health care operational purposes. Douglas Vascular Center is not required to agree to the restrictions that I may request. However, if Douglas Vascular Center agrees to a restriction that I request, the restriction is binding on Douglas Vascular Center.

I have the right to revoke this consent, in writing at any time, except to the extent that Douglas Vascular Center has taken action in reliance on this consent.

By signing this form, I am consenting to Douglas Vascular Center use and disclosure of my PHI to carry out TPO. I am also acknowledging that I have been presented with the Douglas Vascular Center Notice of Privacy Practices.

If I do not sign this consent, Douglas Vascular Center may decline to provide treatment to me.

_____ _____

Signature of Patient, Legal Guardian or Representative Date

_____

Patient's Name (Please Print)