



NOTICE OF PRIVACY PRACTICES WAIVER

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **Cedar Park Surgeons, PA** to use and disclose my protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). The notice of Privacy Practices provided by **Cedar Park Surgeons, PA** describes such uses and disclosures in detail and is available for your review.

I have the right to review the Notice of Privacy Practices prior to signing this consent (posted in the waiting room). **Cedar Park Surgeons, PA** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

**Privacy Officer @ Cedar Park Surgeons
1401 Medical Parkway B, Ste. 101
Cedar Park, Texas 78613**

With this consent, **Cedar Park Surgeons, PA** may call my home or any alternative number listed on my account and leave a message on voicemail or in person that reference any items necessary for conducting standard TPO; including, but not limited to appointment reminders, insurance items, calls of clinical care, test results, or financial status.

With this consent, **Cedar Park Surgeons, PA** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient financial statements.

With this consent, **Cedar Park Surgeons, PA** may speak with _____ (ie: spouse's name) to assist the practice in carrying out TPO, such as discussing any open or unpaid balances of my financial account, including visit reason and insurance related matters. Unless otherwise stated at time of service by signing the Restriction of Use and Disclosure of Protected Health Information Form denying access to the specific reason stated on form.

I have the right to request that **Cedar Park Surgeons, PA** restrict how it uses or disclosed my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Cedar Park Surgeons, PA** to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Cedar Park Surgeons, PA** may decline to provide treatment for me. Restrictions to this consent could create situations which our practice is unable to maintain our standard TPO.

Patients Signature or Legal Guardian (under 18)

Printed Patient/Guardian Name

Today's Date (Required renewal every year)