Patient Consent for Use and Disclosure
of Protected Health Information

I hereby give my consent for Brooklyn Surgical PLLC to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO).

I have the right to review the Notice of Privacy Practices provided and posted in the office prior to signing this consent. Brooklyn Surgical PLLC reserves the right to revise the Notice pf Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Brooklyn Surgical PLLC**.**

With this consent, Brooklyn Surgical may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carry out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Brooklyn Surgical may e-mail/text or mail to my home or other alternatives location any items that assist the practice in carrying out TPO, such as appointment reminders cards and patient statements as long as they marked "Personal and Confidential."

I have the right to request that Brooklyn Surgical PLLC restrict how his office uses or disclose 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 Brooklyn surgical PLLC 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, Brooklyn Surgical PLLC may decline to provide treatment to me.

_____
Signature of Patient or legal Guardian

_____ _____
Print Patient's Name Date

_____
Print Name of Patient or Legal Guardian, if applicable