CONSENT TO USE OR DISCLOSE MEDICAL INFORMATION

Oregon Surgical Specialists, PC

I authorize Oregon Surgical Specialists, PC to use and disclose the information of
____________________________ for the purposes defined below:
Printed Patient Name

***Treatment** includes activities performed by a physician, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers my/our practice by telephone as the on-call physician.

***Payment** includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefits claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, precertification and preauthorization. Also includes billing information shared with from the hospital or surgery center.

***Health Care** operations include the necessary administrative and business functions of our office.

You may review Oregon Surgical Specialists, PC detailed and extended "Notice of Privacy Practices" for additional information about the uses and disclosures of information described in this consent prior to signing this consent. This copy is posted in our waiting room on the "resource center" board.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the notice may change from time to time.

I understand that I have the right to revoke this consent provided that I do so in writing, except to the extent that Oregon Surgical Specialists, PC has already used or disclosed the information in reliance on this consent.

______________ ____**(or)**
Date Signature of Patient

______________ ____
Date Signature of Legal Representative