Desert West Surgery

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Desert West Surgery to use and disclose protect health information (**PHI**) about me to carry out treatment, payment and health care operations (**TPO**). The Notice of Privacy Practices provided by Desert West Surgery describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Desert West Surgery 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:

Desert West Surgery
1111 Shadow Lane
Las Vegas, NV 89102

With this consent, Desert West Surgery 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 carrying out **TPO**, such as appointment reminders, insurance items and calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Desert West Surgery may mail to my house or other alternative location any items that assist the practice in carrying out **TPO**, such as appointment reminder cards and patient statements.

With this consent, Desert West Surgery may e-mail to my home or other alternative location any items that assist the practice in carrying out **TPO**, such as appointment reminder cards and patient statements. I have the right to request that Desert West Surgery restrict how it uses or discloses 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 Desert West Surgery 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, Desert West Surgery may decline to provide treatment to me.

Signature of Patient or Legal Guardian

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Print Patient's Name and Date

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Print Name of Patient of Legal Guardian, if applicable