Surgical Associates of Atlanta, P.C.
550 Peachtree Street N.E.
Suite 1215
Atlanta, Georgia 30308
(404)688-1934

PATIENT CONSENT FORM

For Use and Disclosure of Protected Health Information

By signing this for, you consent to our use and disclousre of protected health information about you for treatment, payment and health care operations. Our Notice of Privacy Practices ("Notice") provides a complete description about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this consent. By signing this consent, you acknowledge that you have had the opportunity to review the Notice and received a copy if you wanted one. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by requesting a copy in writing from Surgical Associates of Atlanta, P.C.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

The Surfical Associates of Atlanta, P.C. has the right to refuse to treat you if you do not sign this consent. If you sign this consent and then later revoke it, Surgical Associates of Atlanta, P.C. has the right to refuse to provide further treatment to you as of the day of your revocation. I consent to Surgical Associates of Atlanta, P.C.'s use and disclosure of my health information as described in its Notice of Privacy Practices. My signature below indicates that I have been given a chance to review a current copy of the Surgical Associates of Atlanta, P.C.'s "Notice of Privacy Practices".

_____
Patient Name (Please Print)

_____ _____
Signature of Patient (or legal Representative) Date

_____
Relationship to Patient