GREATER CHESAPEAKE HAND SPECIALISTS, P.A.
LUTHERVILLE SURGICENTER, LLC
PATIENT CONSENT
USES AND DISCLOSES REQUIRING AN OPPORTUNITY FOR THE INDIVIDUAL TO AGREE OR OBJECT

Patient's Name: _____ Date of Birth: _____ Date: _____

By signing this form, I consent to GCHS' or LSC's use and disclosure of my Protected Health Information for the purposes of *treatment, payment and/or health care operations* as defined in the Privacy Notices of GCHS or LSC.

_____ _____
Signature of Patient or Legal Representative Witness

I acknowledge receipt of the Notice of Privacy Practices._____
Patient's Initials

CONTACT INFORMATION

1) HOW SHOULD WE CONTACT YOU?

You have the right to request us to contact you in a certain way or at a certain place. Please let us know if you have a contact preference, e.g. cell phone, home, work.

_____
_____

2) TO WHOM MAY WE DISCLOSE (Person to whom GCHS or LSC MAY USE OR DISCLOSE PHI*)

Name: _____
Relationship to patient: _____
Address: _____ Home Tel: _____
_____ Work Tel: _____
Other contact information, e.g. cell phone _____

3) TO WHOM MAY WE NOT DISCLOSE (Person to whom GCHS or LSC MAY NOT USE OR DISCLOSE PHI*)

Name: _____
Relationship to patient: _____

*PHI: Protected Health Information