Southeastern Surgical Associates, PC
100 Camp Street
Hyannis, MA 02601
508-775-1984

Consent for Release of Protected Health Information

I, _____, consent to the release of protected health information, that is required to carry out treatment, payment of healthcare operations on my behalf.

I have read the Notice of Privacy Practices and I am aware of the following:

- I have the right to place restrictions on the way my protected health information is used or disclosed.
- I understand that *Southeastern Surgical Associates, PC* is not required to agree with my requested restrictions. I also understand that once *Southeastern Surgical Associates, PC* agrees to my restrictions, it must comply with those restrictions.
- I have a right to revoke my consent for the use and disclosure of my protected health information at any time. I understand that, if I choose to revoke my consent, I must submit a written statement that I have signed.
- I understand that *Southeastern Surgical Associates, PC* must immediately comply with my request to revoke consent, except to the extent that it has already taken some action that was based on my original consent.
- I understand that *Southeastern Surgical Associates, PC* has reserved the right to change from time to time the privacy practices that are described in the Notice of Privacy Practices. Whenever changes are made to these practices, I understand that I will be notified accordingly through publication.

Individual:	Witness:
X_____	_____
signature	*signature*
_____	_____
print name	*print name*
_____	_____
date	*date*

I hereby acknowledge that I have received and read a copy of *Southeastern Surgical Associates, PC*'s Notice of Privacy Practices.

X_____	_____
signature	*date*
_____	**Submit Form**
print name	