



JOHN W. BAKER, M.D., P.A.

GENERAL AND BARIATRIC SURGERY

JOHN W. BAKER, M.D., F.A.C.S.

DIPLOMAT AMERICAN BOARD OF SURGERY

## Patient Consent for Use and Disclosure of Protected Health Information

In signing this form, you consent to the use and disclosure of your protected health information by [practice], our staff, and our business associates strictly for the purpose of treatment, payment and health care operations.

You acknowledge you have had an opportunity to review our **Notice of Privacy Practices** prior to signing this consent. We encourage you to review our **Notice of Privacy Practices** carefully. It provides more detail on how we may use and disclose your information. The **Notice of Privacy Practices** may change. A current copy may be requested when you are being seen as a patient, by contacting our manager at 501-221-9175 or by visiting our web site at [http://\\_WWW.OBESITY-SURGERY.NET](http://_WWW.OBESITY-SURGERY.NET)

You may request that we restrict how we use and disclose your protected health information for the purposes mentioned above. If you would like to request a restriction, please do so in writing. However, we reserve the right to deny your request. If we grant your request, we are bound by the terms of the agreement.

You may also revoke this consent in writing; however, information on any treatment / service provided using this or prior consents may still be used or disclosed for purposes of treatment, payment, or health care operations. Refer to the **Notice of Privacy Practices** for further information.

***By signing this form, I grant my consent to the medical practice use and disclose my protected health information for the purposes of treatment, payment and health care operations.***

\_\_\_\_\_  
Signature of Patient or Surrogate Decision Maker: Date: \_\_\_\_\_

Relationship to Patient/ Legal authority (if applicable): \_\_\_\_\_

### For Practice use only

Failure to obtain consent Check the appropriate reason:

Indirect Treatment Relationship     Emergency treatment  
 Substantial Communication Barrier     Refusal to Sign     Other

Description: \_\_\_\_\_  
\_\_\_\_\_

Practice Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_