CHRIAS
Christiana Institute of Advanced Surgery

CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA ***Eff. 8/28/13***

Patient Consent for Use and Disclosure of Protected Health Information

The individual whose signature appears below hereby attests to the following statements:

With my consent, CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA, may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Please refer to CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA's Notice of Privacy Practices for a more complete description of such uses and disclosures.)

With my consent, CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA may disclose my PHI to the following individuals (family, relatives, or friends) who may assist in my care:

Name	Relationship	Home #:	Work #:	Cell #:

I have the right to review the Notice of Privacy Practices prior to signing this consent. CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA reserves the right to revise its Notice of Privacy Practices at any time. A written copy of our Notice of Privacy Practices may be obtained by forwarding a written request to our office.

CONSENT FOR CALLS TO HOME
With my consent, CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA may call my home or other designated location and leave message on my voice mail or with a person listed above in reference to any item that may assist CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results, among others.

CONSENT FOR MAIL
With my consent, CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA may mail to my home or other designated location any item that may assist CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA in carrying out TPO such as appointment reminder cards and patient statement as long as they are marked CONFIDENTIAL.

CONSENT FOR E-MAIL
With my consent, CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA may e-mail to my designated e-mail address any message in reference to any item that may assist in my care.

CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA may contact me for TPO use, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results, among others.

I have the right to request that CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA restricts how it uses or discloses my PHI to carry out the TPO, However, CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA 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 CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA has already made disclosure in reliance upon my prior consent. If I do not sign this consent, CHRISTIANA INSTITUTE OF ADVANCED SURGERY, PA may decline to provide services to me.

Signed by: _____ _____
Signature of Patient Date

_____
Patient's Name

(PATIENT WILL BE PROVIDED WITH A SIGNED COPY OF THIS AUTHORIZATION)