Orthopaedic Surgery & Sports Medicine
OF SAN ANTONIO

Consent for Purpose of Treatment, Payment, Healthcare Operations and Notice of Privacy Practices

I consent to the use or disclosure of my protected health information by Orthopaedic Surgery & Sports Medicine of San Antonio, hereby referred to as OSSMSA, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of OSSMSA. I understand that diagnosis or treatment of me by **Andrew L. Whaley, M.D. or Joseph Taylor, F.N.P.** may be conditioned upon my consent as evidence by my signature on this document. I understand that Andrew L. Whaley, M.D. and/or Joseph Taylor, F.N.P. may provide care to me in facilities such as Alamo City MRI and Alamo Heights Surgery Center in which they may have a financial interest.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practices. OSSMSA is not required to agree to the restrictions that I may request. However, if OSSMSA agrees to a restriction that I request, the restriction is binding on OSSMSA and _____.
(Write your name here)

I have the right to revoke this consent, in writing, at any time, except to the extent that **Andrew L. Whaley, M.D., Joseph Taylor, F.N.P.** or OSSMSA has taken action in reliance on the consent.

My "Protected Health Information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review OSSMSA's Notice of Privacy Practices prior to signing this document. The OSSMSA Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the OSSMSA. The Notice of Privacy Practices for OSSMSA is also available at the front desk of each clinic and on the OSSMSA website at **www.ossmsa.com**. This Notice of Privacy Practices also describes my rights and the OSSMSA duties with respect to my protected health information.

OSSMSA reserves the right to change the privacy practices described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by accessing the OSSMSA website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority