SURGICAL CLINIC ASSOCIATES, P.A.

501 Marshall Street, Suite 500
Jackson, MS 39202
Phone: (601)948-1411
Facsimile: (601)948-0090

PATIENT_____**DATE OF BIRTH**_____**MRN**_____

Surgical Clinic Associates, P.A. complies with the Health Insurance Portability and Accountability Act (**HIPAA**). **HIPAA** provides certain rights and protections to you as a patient. Patient information will be kept confidential except when necessary to provide services. These services include sharing information with other healthcare providers, specialists and health insurance companies to receive payment for services. I agree to the terms outlined, have been offered and will receive a full version of the HIPPA policy upon request. Patient Health Information may be disclosed to the following authorized person(s), including family members:

Name_____Relationship_____

Name_____Relationship_____

E-Prescribing PBM is defined as a physician's ability to electronically send or receive an accurate, error free and understandable prescription directly to or from your pharmacy. By signing this consent form, you are agreeing that Surgical Clinic Associates can request, send and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payouts for treatment purposes.

Medical Records Release I authorize the release of my PHI (protected health information) to **Surgical Clinic Associates, P.A.**, or any physician involved in my care to be used for medical treatment.

___Complete medical record ___ other (path, x-ray, operative report) ____Specific date(s)

I understand the terms covered regarding the **HIPAA, Medical Records Release and PBM** consents. I agree and authorize Surgical Clinic Associates to use my private healthcare information to render medical treatment.

Signature of Patient/Representative

Name_____**Date**_____