

# General Surgery

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## 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 Bariatric Surgical Specialists, PA, 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 (919) 234-4470 or by visiting our website at [www.carysurgical.com](http://www.carysurgical.com)

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 and services 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 for the practice to use and disclose my protected health information for the purposes of treatment, payment and health care operations

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Parent if Minor \_\_\_\_\_ Date \_\_\_\_\_  
Power of Attorney Signature \_\_\_\_\_ Date \_\_\_\_\_  
Name of other that may have your records \_\_\_\_\_ Date \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_

### For Practice Use Only

Failure to obtain consent:

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

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

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

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