CENTRAL ARKANSAS SURGICAL CENTER

PATIENT INFORMATION CONSENT FORM

PATIENT RIGHTS AND RESPONSIBILITES

ACKNOWLEDGEMENT OF PHYSICIAN OWNERSHIP

ACKNOWLEDGEMENT OF ADVANCE DIRECTIVES/LIVING WILL

_____ I have read, received a copy and fully understand *Central Arkansas Surgical Center* Notice of Information Practices. I understand that *Central Arkansas Surgical Center* may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I also understand that *Central Arkansas Surgical Center* will consider requests on a case-by-case basis and does not have to agree to requests for restrictions. I hereby consent to the use and disclosure of my personal health information for purposes as noted in *Central Arkansas Surgical Center's* Notice of Information of practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____ I have read, received a copy and fully understand *Central Arkansas Surgical Center's* Patient Rights and Responsibilities.

_____ I have read and received a copy of the Physician Ownership List for *Central Arkansas Surgical Center*. I understand a list of alternative facilities will be provided to me at my request. By signing I am confirming that I have been made aware of the Physician's ownership interest in *Central Arkansas Surgical Center*. Based on this knowledge, I have agreed to have my surgery at *Central Arkansas Surgical Center.*

_____ I have advised *Central Arkansas Surgical Center* that I have a Living Will and/or Advanced Directives. I acknowledge that I will provide their office with a copy of this document to be a part of my medical records.

_____

Signature

_____

Patient Name (Printed)

_____

Witness Signature

_____

Date