ANESTHESIA SERVICES OF LYNCHBURG, INC.
CONSENT TO USE/DISCLOSE HEALTH INFORMATION FORM

Although Anesthesia Services of Lynchburg, Inc. is not required by law to obtain a signed consent from you for treatment, payment, or healthcare operation purposes, we encourage you to sign this consent so that you are aware of our concern and practices regarding protection of your personal health information.

Should you desire a more complete description of the permissible uses and disclosures of your protected health information, you have the right to review a Notice of Privacy Practices (the "Notice") prior to signing this consent.

The notice is available by contacting the Privacy Officer. Please note that Anesthesia Services of Lynchburg, Inc. reserves the right to change the privacy practices described in the Notice. Should you wish to obtain a revised Notice, please contact the Privacy Officer.

By signing this consent, you agree that Anesthesia Services of Lynchburg, Inc. may use or disclose your protected health information to carry out treatment, payment, or health care operations.

You have the right to request that Anesthesia Services of Lynchburg, Inc. restrict how your protected health information is used or disclosed to carry out treatment, payment, or healthcare operations. However, Anesthesia Services of Lynchburg, Inc. is not required to agree to such restrictions. If Anesthesia Services of Lynchburg, Inc. does agree to a restriction that you request, such restriction will be binding.

You have the right to revoke this consent in writing, except to the extent that Anesthesia Services of Lynchburg, Inc. has taken action in reliance on your consent.

Acknowledgement and Agreement:

I consent to Anesthesia Services of Lynchburg, Inc. sending protected health information to the insured in the event that I am receiving treatment but am not the insured under my insurance policy. Such information may include, but not be limited to, explanation of benefits ("EOB") or invoices regarding my treatment. I understand that if I do not want such protected health information mailed to the insured, then I will notify Anesthesia Services of Lynchburg, Inc. of my objection and will complete a Request for Restriction of Use and Disclosure Form.

I consent to Anesthesia Services of Lynchburg, Inc. releasing my religious affiliation to religious clergy.

I consent to Anesthesia Services of Lynchburg, Inc. releasing my protected health information to the following individuals:

_____ _____

Name Relationship to Patient

_____ _____

Name Relationship to Patient

I have received a copy of Anesthesia Services of Lynchburg, Inc.'s Notice of Privacy Practices.

I hereby certify that I have read the provisions set forth in this consent. I understand and agree to the terms of this consent.

_____

Print Patient's Name

_____ _____

Signature of Patient or Representative Date

_____ _____

Name of Personal Representative (if applicable) Relationship to Patient