Frederick Rau MD | David Rau MD | Eric Rau MD | Donald Schwab Jr MD

PATIENT CONSENT AND ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I understand that as part of the provision of healthcare services, Bayou Surgical Specialists, LLC creates and maintains health records and other information describing, among other things, my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment, and healthcare operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

A copy of Bayou Surgical Specialists' Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information as permitted under federal and state law has been made available to me and is posted in our office. I understand that the organization reserves the right to change their Notice and practices and that I may obtain a current copy from the office at any time.

This consent is freely given with the understanding that:

1. Any and all records are confidential and cannot be disclosed for reasons outside of treatment, payment or healthcare operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested.

CONSENT TO SHARE INFORMATION WITH FAMILY / FRIENDS

I authorize Bayou Surgical Specialists to verbally discuss my care using their best judgement and grant permission to disclose health information that is relevant to my care or payment for my care (including but not limited to test results, appointments, medications, diagnosis, and treatment) with the following family member(s) / friends until I revoke said authorization in writing:

Name: ____Phone #: ______________________

Name: ____Phone #: ______________________

Name: ____Phone #: ______________________

Name: ____Phone #: ______________________

Patient's Printed Name: ____ DOB: _________________

Patient's Signature (or representative): ____________________________ Date: ________________

If Authorized Representative, please list relationship to patient: _______________________________