



LAKESIDE SURGICAL
ASSOCIATES, PA

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HIPPA Consent Form

I authorize Lakeside Surgical Associates and/or their staff to leave medical information pertaining to my care on the phone/cell/work numbers that I have provided on page 1. I will assume responsibility to notify them whenever this information changes. I authorize Lakeside Surgical Associates to disclose to the following person(s) or entity medical information regarding my care.

Spouse/ Parent/ Other Person (please circle) _____ (Name)
dob _____

Fax medical records to medical doctor or new referral doctor _____

Please list any person or entity you do **not** want _____ (Name)
us to release your private health information

You acknowledge you have had an opportunity to review our Notice of Privacy Practices prior to signing this consent.

By signing this form, I grant my consent to Lakeside Surgical Associates to use and disclose my protected health information for the purposes of treatment, payment and health care operations.

Signature of Patient/POA/ Surrogate Decision Maker

Date