



**TORRANCE SURGERY CENTER  
CONSENT TO THE USE AND DISCLOSURE OF  
HEALTH INFORMATION FOR TREATMENT, PAYMENT,  
OR HEALTHCARE OPERATIONS**

I understand that as part of my healthcare, Torrance Surgery Center creates and maintains health records describing my health history. I understand that the surgery center may use this information as:

1. a basis for planning my care and treatment;
2. a means of communication among many health professionals who contribute to my care;
3. a means by which third-party payors can verify that services billed were actually provided; and
4. a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I have been provided a Notice of Torrance Surgery Center's Privacy Practices, which provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the surgery center reserves the right to change its notice and practices. If the surgery center changes the notice, I can obtain a revised copy by asking the administrator of the surgery center. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or other healthcare operations and that the surgery center is not required to agree to the restrictions requested. If the surgery center does agree to such restrictions, however, the surgery center must comply with such restrictions. I understand that I may revoke this consent in writing, except to the extent that the surgery center has already taken action in reliance on it.

\_\_\_\_\_ I request the following restrictions to the use or disclosure of my health information.

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Effective Date of Notice: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of patient or patient's representative \_\_\_\_\_

Printed name of patient's representative: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_