CENTER FOR PLASTIC SURGERY

PATIENT CONSENT FORM

1. I acknowledge that I have been given a copy of the Practice's "HIPAA Privacy Notice" which describes the Practice's obligation to ensure the privacy of my health information. The HIPAA Privacy Notice also describes how the Practice may use and disclose my health information for treatment, payment and health care operations. I know that I have the right to review the Practice's HIPAA Privacy Notice prior to signing this consent, and I have had the opportunity to read the Practice's HIPAA Privacy Notice and to ask questions about it. I understand that the Practice is required to maintain the privacy of my health information in accordance with the terms of its HIPAA Privacy Notice.

2. I further acknowledge that the Practice can change its HIPAA Privacy Notice in the future, and that I can receive a copy of the Practice's current Privacy Notice at any time by contacting **Debbie Barwick (301) 652-7700** or by checking the Practice's website at www.cpsdocs.com.

3. I understand that I have the right to request that the Practice restrict its uses and disclosures of my health information for treatment, payment, or health care operations. If my restrictions are accepted by the Practice, these restrictions will be binding on the Practice. I also understand that the Practice is not required to agree to my requested restrictions.

   I do not request any restrictions on the Practice's use and disclosure of my health information for treatment, payment, or health care operations. _____ (Initial)

   I agree to receive emails from the practice regarding my treatment at the following email address:

   _____

   Messages may be left on the following telephone number: _____

   You may also speak with:_____ Relationship:_____
   regarding my PHI (including but not limited to procedures, results, insurance, account, etc.)

   I was referred by _____ and give consent for this practice to send this patient a Thank You note. _____ (Initial)

4. By signing this form, I consent to the Practice's use and disclosure of my health information for treatment, payment and health care operations. I understand that I have the right to revoke this consent at anytime in writing, but if I do, my revocation will not have an effect on any actions the Practice has already taken in reliance on this consent.

_____ _____

Signature of Patient or Patient's Representative Date

(This form must be completed before signing)

If this form is signed by a Patient's Representative, please complete the following:

Print the name of Patient's Representative: _____

Describe the representative's authority to act for the patient:

_____

_____

NOTE: YOU MAY REFUSE TO SIGN THIS CONSENT

HOWEVER, IF YOU DO REFUSE, THE PRACTICE MAY REFUSE TO PROVIDE YOU WITH NON-EMERGENCY CARE.