NOTICE OF PRIVACY PRACTICES CONSENT

Patient Name (last, first)____

What would you like to be called?____

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.
You have the right to request that we restrict how protected heath information about you or is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do we shall honor that agreement.
By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent in writing by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The practice has a notice of Privacy Practices and that the patient has the opportunity to review this notice
- The patient has the right to change the Notice of the Privacy Practices
- The patient has the right to restrict the uses of their information but the practice does not have to agree with those restrictions
- The patient may revoke the consent in writing at any time and all future disclosures with then cease
- The practice may condition receipt of treatment upon the execution of this Consent.

PLEASE REVIEW, COMPLETE, AND INITIAL ALL OF THE FOLLOWING

Date of Birth______________________________

______ **If you call the office and request any information from your medical chart, you will be required to**
INITIAL **provide the office with the last four digits of your Social Security # before any information can be discussed.**

_____ **All correspondence will be mailed to the address you have provided on your registration form. You will be**
INITIAL **provided with a new registration form if you wish to change your address or any other information.**

_____ **Do we have permission to mail occasional promotions, events, discounts, or announcements of new cosmetic**
INITIAL **treatments, services or products to your address?** ☐ **Yes** ☐ **No**

_____ **Your scheduled appointments will be confirmed at your home or mobile number.**
INITIAL

_____ **Any information from your medical chart (test results, etc.) will be communicated in the following way:**
INITIAL

HOME TELEPHONE________________________________

- ☐ Message with detailed information
- ☐ Message with our name and call-back number only

WORK TELEPHONE________________________________

- ☐ Message with detailed information
- ☐ Message with our name and call-back number only

MOBILE PHONE__________________________________

- ☐ Message with detailed information
- ☐ Message with our name and call-back number only

OTHER____
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My signature below indicates that I have read and understand this consent in its entirety, that my questions have been adequately answered, and that a copy of the Notice of Privacy Practices is available to me upon my request.

______________________________ ____________________________________ ________________

Patient Signature | Staff Signature | Date