CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS.

I understand that as part of my healthcare, The Center for Plastic Surgery, P.S.C. originates and maintains health records describing my health history, symptoms, examination, and test results, diagnoses, treatment, and any plans for future care or treatment.

I understand and have been provided with a *Notice of Information Practices* that provides me 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 organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. 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 healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

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

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Signature of Patient or Legal Representative   Witness

Date

****Our office periodically sends out literature and special offers to our patients, Please sign below if you consent to our office sending this to your home address. ****

Signature of Patient   Witness