

## PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that as part of my health care, Gulf Coast Plastic Surgery originates, records, and maintains health information about me describing my health history, symptoms, examination and test results, diagnosis, treatment, and plans for future care or treatment. I understand that this health information may be used and disclosed by Gulf Coast Plastic Surgery for treatment, payment, and health care operations. For example, my health information serves as:

- a basis for planning my care and treatment;
- a means of communication among the many health professionals who contribute to my care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payor can verify that services billed were actually provided; and
- a tool or routine health care operations, such as assessing quality and reviewing the competence of health care professionals.

\_\_\_\_\_ (*please initial*). I understand that I have the right to request restrictions as to how my health information may be disclosed to carry out treatment, payment, or health care operations. Gulf Coast Plastic Surgery is not required to agree to the restrictions as requested, but if it does, it is bound by such restrictions.

\_\_\_\_\_ (*please initial*). I understand that I may revoke this consent in writing, except to the extent that Gulf Coast Plastic Surgery has already taken action in reliance thereon.

\_\_\_\_\_ (*please initial*). By signing this form, I consent to Gulf Coast Plastic Surgery use and disclosure of my health information for treatment, payment, and health care operations.

\_\_\_\_\_ (*please initial*). I acknowledge that I have been provided with Gulf Coast Plastic Surgery Notice of Privacy Practices that provides me a more complete description of information uses and disclosures. I understand that I have the right to review the Notice of Privacy Practices prior to signing this consent. I understand that Gulf Coast Plastic Surgery reserves the right to change its Notice of Privacy Practices and a revised copy will be given to me at my next visit at Gulf Coast Plastic Surgery.

## RECEIPT OF FINANCIAL POLICIES

\_\_\_\_\_ (*please initial*). I acknowledge that I have received and read a copy of Gulf Coast Plastic Surgery financial policies.

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Signature of Patient / or Legal Guardian

\_\_\_\_\_  
Date