HALL WRYE
PLASTIC SURGEONS & MEDICAL SPA

PATIENT CONSENT OF NOTICE OF PRIVACY PRACTICES: PF-2000

HALL AND WRYE PLASTIC SURGEONS

We reserve the right to modify the privacy practices outlined in the notice.

I, _____ understand that as part of my healthcare, Hall and Wrye Plastic Surgeons uses and discloses paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnoses, treatment and any plans for future care of treatment. I understand that this information serves as a basis of planning care and treatment, communication among the many health professionals who contribute to my care, a source of information for applying my diagnoses and surgical information to my bill, by which and third-party-payer can verify such as assessing quality and reviewing the competence of health care professionals. I understand that I have been provided with a ***Notice of Information Practices*** that provided a more complete explanation of information uses and disclosers. I understand that as part of this organization treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax. Should Hall and Wrye Plastic Surgeons change their notice, I will be sent a copy of any revised notice to the addressed I've provided (whether U.S. mail or, if I agree, E-mail) see ***Section 164.520*** of the ***Code of Federal Regulations***.

I wish to have the following restrictions to the use of disclosure of my health information:
I understand that Hall and Wrye Plastic Surgeons is not required to agree to the restrictions requested and that I may revoke this consent in writing, except to the extent that the organization has already taken action in the reliance thereon. I understand that by refusing to sign this consent can result in refusal of treatment, see ***Section 164.506*** of the ***Code of Regulations***.

I fully understand the terms of this consent.

X_____ _____
Patient Signature or Representative **Date**

I acknowledge that Hall and Wrye Plastic Surgeons has given me a copy of the Notice of Privacy Practices (HIPPA).

X_____
Patient Initials

For Office Use Only

- ☐ Consent was given on _____ and taken by_____
- ☐ Consent refused by patient, and treatment refused as permitted
- ☐ Consent added to the patient's medical records on _____