PLASTIC & RECONSTRUCTIVE SURGERY, PC

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CONSENT FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

All personal medical records, paper or electronic, written or oral, are viewed by the government regulations as protected health information (PHI). Protecting your privacy is the standard for us. Every employee is expected to protect your private information.

You have been given a copy of our current NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION, which provides detailed information regarding your protected health information, and how it may be used and/or disclosed by this office. **Read it carefully before completing and signing this form.**

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required to grant your request, but if we do, the restriction will be binding on us. You must understand that if there are restrictions, we may not be able to provide treatment to you. *We reserve the right to refuse care to any patient who restricts the use of private health information to the extent that we are unable to reasonably care for you and/or bill for our services according to insurance contracts.*

IF YOU *DO NOT* want us to release information regarding the following, please check:

o AIDS / HIV o PSYCHIATRIC/MENTAL HEALTH TREATMENT o SUBSTANCE ABUSE

There may be times when we need to contact you regarding test results, remind you of an appointment, or change an appointment. Please let us know how you want us to handle this:

o If I'm not home, leave a message on my answering machine

o You may leave a message with (Give names & relationship to you) _____

_____

o I prefer that you do not call or leave messages at my home:
Contact me by: □ Cell Phone #: _____ □ Office #: _____

Other: _____

o I authorize Dr. Brantner's staff to speak with the following regarding my medical care (Give Name & Relationship):

Name: _____ Relationship _____

IMPORTANT: ***Callers will be asked to identify you by:*** *1) your full name, 2) your date of birth and 3) your maiden name, or your MOTHER'S maiden name if you are male, or a child*

- Realize that the staff of Plastic & Reconstructive Surgery, PC will divulge information **ONLY to individual(s) you designated, *and who can provide the information noted***. *Please make sure those you designate know this.*

I hereby give consent to Plastic & Reconstructive Surgery, PC to use and disclose my protected health information for the purposes of treatment, payment and health care operations.

Name: _____ DOB: _____
PRINT PATIENT NAME

Signed: _____ Date: _____

*If not patient, state relationship to patient: _____

If the patient is under 18 years of age, or legally incompetent of making determinations regarding his or her own health care, this form must be signed by a Legal Guardian or someone with Power of Attorney for the patient's health care. A copy of the legal document must be in the patient's record.

You may revoke this consent at any time. It must be in writing, signed by you or on your behalf, by someone legally representing you, and delivered to the address at the top of this form. You may deliver your revocation by any means you choose (e.g., personally or by fax or mail), but it will be effective only when we actually receive it. Your revocation will not be effective to the extent that we, or others, have acted in reliance upon this consent.

Reviewed and Revised 02/08