ADVANCED AESTHETICS
LOPEZ PLASTIC SURGERY

Refine • Rejuvenate • Restore

HIPAA COMPLIANCE REQUIREMENT FORM

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

I, _____, understand that as part of my health care, Lopez Plastic Surgery originates and maintains paper and or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the 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 payer can verify services billed were provided, and
- A tool for routine healthcare such as assessing quality and reviewing the competence of healthcare professionals

Should it become necessary to disclose my protected information to another entity for the above purposes, I consent to such disclosure for these permitted uses, including disclosures via fax and transcription. My signature acknowledges that I have the right to receive a copy of the notice of privacy policies brochure from Lopez Plastic Surgery.

_____ _____

Signature of Patient (Parent or Guardian if patient is a Minor) Date

On occasion, we may have to convey confidential health information to you by telephone. Please indicate your preference for the following:

_____ Write only, do not call

_____ Please call ( ) _____-_____ (detailed message can be left _____)

My confidential health information may be discussed with the following people:

1. _____ 2. _____