Artisan Plastic Surgery, LLC

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, APS, LLC 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 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-payer can verify that services billed were provided, and
A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I understand and have been provided with a ***Notice of Information Practices*** that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

The right to review the notice prior to signing this consent,
The right to object to the use of my health information for directory purposes, and
The right to request restriction as to how my health information may be used or disclosed to carry out treatment, payment, or health care operation.

I understand that APS, LLC 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 also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.520 of the Code of Federal Regulations.

I further understand that APS, LLC reserves the right to change their notice and practices and prior implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should APS, LLC change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, If I agree email).

I wish to have the following restrictions to the use or disclosure of my health information:
_____
_____
_____

I understand that as part of this organization's 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 via fax.

I fully understand and **ACCEPT *OR* DECLINE (PLEASE CIRCLE ONE)** the terms of this consent.

_____ _____
Patient's Signature (authorized representative signing for patient) Date

FOR OFFICE USE ONLY

[ ] Consent received by _____ on _____.
[ ] Consent refused by patient, and treatment refused as permitted.
[ ] Consent added to the patient's medical record on _____.

Original Form Concept of The Medical Management Institute, Alpharetta, Georgia (4/2003)