Plastic Surgery Associates of Valdosta
230 Northside Drive, Valdosta, GA 31602
229-242-3002 Phone
229-242-0644 Fax

Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

Patient Name _____ **Date** _____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Plastic Surgery Associates of Valdosta may use or disclose my protected health information for treatment, payment or health care operations-which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Plastic Surgery Associates of Valdosta has a detailed document call the **'Notice of Privacy Practices.'** It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the 'Notice' before signing this agreement. If I ask, Plastic Surgery Associates of Valdosta will provide me with the most current *Notice of Privacy Practices.*

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices.* My signature means that I agree to allow Plastic Surgery Associates of Valdosta to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Plastic Surgery Associates of Valdosta has taken action relying on this consent.

Consent for Communications

You have the right to request that we restrict how protected health information about you is used or disclosed. Most patients have family members and friends that occasionally become involved in their care. (For example, your spouse calls to confirm your appointment time; OR your adult child calls with questions about your medications.) Please list any restrictions to the information you have regarding how we can communicate with those you have listed below. (Example: Appointments only, financial matters only; Medications only, etc. If there are no restrictions, please list "NONE" beside their name.

Please list below any persons you will allow us to talk with about you. (If you prefer we do not speak with anyone, please write "NO ONE" across this section.

Name	Relationship to You	Phone Number	Restrictions (See instructions above.)

_____ _____

Signature (Patient or Legal Custodian/Authorized Representative) Date

_____ _____

Relationship to Patient if signed by another party Date