CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

ESTETICA
COSMETIC & RECONSTRUCTIVE SURGERY OF SCOTTSDALE

Practice Administrator
9450 E Ironwood Square Dr.
Scottsdale, AZ 85258
Phone: (480) 551-0581
Fax: (480) 551-0585
www.anewbeautifulyou.com

SECTION A: PATIENT CONSENT

Name: _____

Address: _____

Telephone: _____

Social Security: _____ - _____ - _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

The purpose of this consent: By signing this form, you give Estetica consent to use and disclose your protected health information to carry out treatment, payment activities and healthcare operation.

NOTICE OF PRIVACY PRACTICE:

You have the right to read our **NOTICE OF PRIVACY PRACTICES** before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operation, of the uses and disclosures we may make of your protected health information and other important matters about your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our **Notice of Privacy Practices**. If we change our privacy practices, we will issue a revise **Notice of Privacy Practices**, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy practices, including any revision s of our notice at any time by contacting:

Practice Administrator
9450 E Ironwood Square Dr.
Scottsdale, AZ 85258
Phone: (480) 551-0581
Fax: (480) 551-0585

Right to Revoke:

You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contract person listed above. Please understand that revocation of this consent will not affect any action we took in reliance of this consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this consent.

SIGNATURE:

I, _____ have had full opportunity to read and consider giving my consent to your use and disclosure of my protected health information to carry out treatment.

SIGNATURE: _____ DATE: _____

If a personal representative on behalf of the patient signs this consent, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

You are entitled to a copy of this consent after you sign it.

REVOCATION OF CONSENT:

I am revoking my consent for your use and disclosure of my protected health information for treatment, payment activities and healthcare operations.

I understand that revocation of my consent will not affect any action you took in reliance on my consent before you received this written **NOTICE OR REVOCATION**. I also understand that you may decline to treat or to continue to treat me after I have revoked my consent

Signature: _____ Date: _____