The Piazza Center
FOR PLASTIC SURGERY & ADVANCED SKIN CARE

PROTECTED HEALTH INFORMATION

Name: _____ **DOB**: _____

Please review the following policies and acknowledge receipt by your signature.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

- I hereby acknowledge that I have been offered, received or viewed a copy of The Piazza Center (TPC) Notice of Privacy Practices (NPP).
- With my consent, TPC may use and disclose protected health information about me to carry out treatment, payment and healthcare operations as discussed in the NPP.
- I may revoke my consent in writing except to the extent that the practice has already made disclosures relying upon my prior consent. If I do not sign this consent, TPC may decline to provide treatment.

****Signature**:** _____Date: _____
Patient / Responsible party

Signatures on this page expire one year from date signed. A new signature is required yearly.

For Clinic Use

_____Patient refused to sign Patient unable to sign because _____

Employee Signature: _____ Date: _____

5920 West William Cannon, Building Seven, Austin, Texas 78749
P: 512.288.8200 F: 512.861.2429