Consent for Purposes of Treatment, Payment

And Healthcare Operations

(HIPAA)

I, ______________________________, consent to the use or disclosure of my protected health information by **Goldfingers Aesthetics & Plastic Surgery** for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of **Goldfingers Aesthetics & Plastic Surgery**. I understand that diagnosis or treatment of me by **Goldfingers Aesthetics & Plastic Surgery** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Goldfingers Aesthetics & Plastic Surgery** is not required to agree to the restrictions that I may request. However, if **Goldfingers Aesthetics & Plastic Surgery** agrees to a restriction that I request, the restriction is binding on **Goldfingers Aesthetics & Plastic Surgery**

I have the right to revoke this consent, in writing, at any time, except to the extent that **Goldfingers Aesthetics & Plastic Surgery** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a medical insurance provider, or my employer. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I authorize **Goldfingers Aesthetics & Plastic Surgery** to communicate with my physicians.

I understand I have a right to review **Goldfingers Aesthetics & Plastic Surgery** "Notice of Privacy Practices" prior to signing this document. The **Goldfingers Aesthetics & Plastic Surgery** Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operation of the **Goldfingers Aesthetics & Plastic Surgery**. The Notice of Privacy Practices for **Goldfingers Aesthetics & Plastic Surgery** is provided at **Goldfingers Aesthetics & Plastic Surgery**. This Notice of Privacy Practices also describes my right and **Goldfingers Aesthetics & Plastic Surgery** duties with respect to my protected health information.

Goldfingers Aesthetics & Plastic Surgery reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy t be sent in the mail or asking for one at the time of my next appointment.

DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT AND FEEL THAT YOU UNDERSTAND IT. ASK ANY QUESTIONS YOU MIGHT HAVE BEFORE SIGNING THIS FORM. DO NOT SIGN THIS FORM IF YOU HAVE TAKEN MEDICATIONS WHICH MAY IMPAIR YOUR MENTAL ABILITIES OR IF YOU FEEL RUSHED OR UNDER PRESSURE.

Print Name ______________________________ Date ____________________

Patient Signature______________________________ Witness ____________________