FLORIDA PLASTIC SURGERY AND MEDSPA

Florida Plastic Surgery and MedSpa
HIPPA Consent for Purpose of Treatment, Payment or Health Care Operations

I consent to the use or disclosure of my protected health information by Florida Plastic Surgery and MedSpa (FPS) for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by Florida Plastic Surgery and MedSpa may be conditioned upon my consent as evidenced by my signature on this document. I understand that 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 health care operations. FPS is not required to agree to the restrictions that I may request. However, if FPS agrees to a restriction that I request, the restriction is binding on the practice. I have the right to revoke this Consent, in writing, at any time, except to the extent that action has been taken in reliance on this Consent.

My "protected health information" means health information, including my demographic information collected from me and collected or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. 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 understand I have a right to review the FPS's Notice of Privacy Practices prior to signing this document. Florida Plastic Surgery and MedSpa's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices the types of uses, and disclosures, of my protected health information that will occur in my treatment, payment of my bills, or the performance of health care operations. A summary of the Notice of Privacy Practices for FPS is also posted/available in the waiting room. This Notice of Privacy Practices describes my rights and the duties of FPS with respect to my protected health information. Florida Plastic Surgery and MedSpa reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Florida Plastic Surgery and MedSpa may decline to provide treatment to me. I may obtain a revised Notice of Privacy Practices by contacting the Privacy Officer at (941) 800-2000.

☐ I, _____, designate the following person to be able to speak to Florida Plastic Surgery and MedSpa, should it be necessary, on my behalf. I hereby give permission to Florida Plastic Surgery and MedSpa and its staff to release to my designee any information about my medical condition or medical needs pr the status of my account and I release Florida Plastic Surgery and MedSpa and staff from any claim of confidentiality in connection with the release of this information.

Name of designated person: _____

Relationship: _____ Phone number:_____

_____

Name of Patient (please print)

_____ _____

Signature of Patient or Representative Date

☐ **I decline to designate another person to speak with Florida Plastic Surgery and MedSpa or staff regarding my care or account.**

_____

Name of Patient (please print)

_____ _____

Signature of Patient or Representative Date