Harris Plastic Surgery
500 Montauk Highway
Suite H
West Islip, NY 11795

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I, ______________________________, am aware that my Protected Health Information will be used by HARRIS PLASTIC SURGERY and disclosed to others for the purposes of treatment (physican to physician or hospital), obtaining payment (insurance company) or supporting the day-to-day health care operations of the practice.

I have received a copy of the Notice of Privacy Practices. I have reviewed the notice prior to signing this consent.

I am aware that I may request a restriction on the use or disclosure of my protected health information. If I should wish to restrict my disclosure, I should make the request in writing.

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Please be aware that our practice, Harris Plastic Surgery, however, may or may not agree to restrict the disclosure of your protected information.

If we agree to your request, the restriction will be binding. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of federal privacy standards.

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date of your revocation of consent is received will not be affected.

This practice reserves the right to modify the privacy practices outlined in the notice.

I have reviewed this consent form and have reviewed the Notice of Privacy Practices. I give my permission to this practice to use and disclose my health information.

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Patient Signature Date