CORNERTSTONE PLASTIC SURGERY

BY FREDERICK A. COVILLE, MD

HIPAA CONSENT FORM

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established a Privacy Rule to help ensure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide standard for certain heath care providers to obtain their patients' consent for uses and disclosures of heath information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your persona medical records strive to do all we can to secure and protect that privacy. When it is appropriate or necessary, we will provide the minimum information needed to those we feel need your health care information regarding treatment, payment, or health care operations in order to provide care that is in your best interest.

We fully support your access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with the physician and not patients) and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be done in writing. Under the law, we have the right to refuse to treat you should you choose to not disclose your personal health information to us. If you choose to give consent in this document, you may request to refuse all or part of your personal health information in the future. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our Privacy Notice (Compliance Assurance Notification to our Patients), to request restrictions and revoke consent in writing.

By signing below, I confirm that I understand this consent form.

Print name: _____

Signature of patient/parent/guardian: _____ Date: _____

Signature of Doctor/Health Professional/Staff: _____ Date _____