ASPS Member Surgeon

CONCANNON
PLASTIC SURGERY

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Plastic & Reconstructive Surgery
Surgery of the Hand

HIPPA Form

Consent for Use and Disclosure of Health Information for Treatment, Payment, Healthcare Operations

Name:_____

Birth date:_____Social Security:_____

I understand that as a part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

I understand that this information serves as:

- ☒ A basis for planning my care and treatment
- ☒ A means of communication among the many healthcare professionals who contribute to my care
- ☒ A source of information for applying my diagnosis and surgical information to my bill
- ☒ A means by which a third-party payer can verify that services billed were actually provided
- ☒ A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals

I understand I have the right to:

- ☒ Object to the use of my health information for directory purposes
- ☒ Request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations, and that the organization is not required to agree to the restrictions requested
- ☒ Revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

_____ **I have received a copy of this office's Notice of Privacy Practices**.
(initial)

_____ **I request the following restrictions to the use or disclosure of my**
(initial) **health information:**_____

_____

_____

_____ _____
Patient/Legal Representative signature Date Witness

**********OFFICE USE ONLY**********

_____ **Accepted** _____ **Denied**

_____ _____ _____
Signature Title Date