Las Colinas Centre for Plastic Surgery
7433 Las Colinas Blvd. • Irving, Texas 75063

Patient Consent & Acknowledgment of Review of Notice of Privacy Practices - HIPAA

I understand that as part of the provision of healthcare services, Dr. Michael R. Whetstone, and Las Colinas Centre for Plastic Surgery create and maintain health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment and any other plans for future care or treatment.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conduction or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purpose of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already made in reliance on my prior consent.

This consent is given freely with the understanding that:

✔ Any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or healthcare operations without my prior written authorization, except as otherwise provided by law.

✔ A photocopy or fax of this consent is as valid as the original.

✔ I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations be restricted. I also understand that the Practice and I must agree to any restriction in writing that I request on the use and disclose of my Protected Health Information and agree to terminate any restrictions in writing on the use and disclosures of my Protected Health Information on which have been previously agreed upon.

At times, we will need to contact you regarding your appointments or health care. What is the best method to reach you? Please answer all that apply.

❑ Home Phone/Voicemail–May we leave a message about health information?	❑ YES	❑ NO
❑ Work Phone – May we leave a message about health information?	❑ YES	❑ NO
❑ Cell Phone/Voicemail – May we leave a message about health information?	❑ YES	❑ NO
❑ Text Message – May we text a message about health information?	❑ YES	❑ NO
❑ Email – May we leave a message via email about health information?	❑ YES	❑ NO

Also, you may request that we disclose or communicate your private health information to family members, other relatives or close personal friends. If you wish to do so, please list their names and numbers.

_____

_____

Printed Patient Name: _____

_____ _____

Signature of Patient or Personal Representative Date (expires in 2 years)