Riverside Plastic Surgery Associates Inc.

Privacy Consent/Disclosure

I give this practice, Sheer Beauty Medical Skincare & Riverside Plastic Surgery Associates Inc., my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed of that I may review the practices Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at this practice.

I understand that I have the right to request a restriction of how my protected health information used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Patient Name (Print):_____
(parent, legal guardian, or authorized representative)

Patient Signature:_____

Date: _____

If signed by patient representative, state relationship to patient:_____

As required by the Privacy Regulations, this may not use or disclose you're your protected health information, except as provided in our notice of Privacy Practices without your authorization. Please list the person that we may disclose your Patients Health Information to if requested.

Please List individuals and their relationship to the patient:
