SARASOTA PLASTIC SURGERY, INC.

"Physician Office"
2255 S. Tamiami Trail, Sarasota, Fl 34239

HIPAA PRIVACY INFORMED CONSENT - PHYSICIAN'S OFFICE

We only use your personal information to help transact the business you have with us. We have established policies to maintain physical, electronic and procedural safeguards to ensure the confidentiality of your personal information. We do not share information about you for marketing purposes. None of your personal or medical information will be used for marketing without your prior written consent.

A Records Release must be signed by you for release of any information to other physicians, practitioners, family or friends.

Please list anyone that you would allow us to discuss your medical condition with below.

PLEASE PRINT

_____Relationship_____

_____Relationship_____

_____Relationship_____

***If you do not want any of your information to be released to any family or friend, initial this statement**

****_____Please DO NOT allow my information to be released to any family/friend.**

Please check the following:

DID YOU RECEIVE A COPY OF OUR NOTICE OF PRIVACY PRACTICES?	**YES_____**	**NO_____**
DO WE HAVE YOUR PERMISSION TO?		
Send information to your home	**YES_____**	**NO_____**
Email you with information	**YES_____**	**NO_____**
May we use your email/mailing address for the purpose of satisfaction surveys?	**YES_____**	**NO_____**
Leave the following information on your PERSONAL voicemail or answering machine:		
Appointment information	**YES_____**	**NO_____**
Billing information	**YES_____**	**NO_____**
Medical information	**YES_____**	**NO_____**
Leave the following information on your WORK answering machine/voicemail:		
Appointment information	**YES_____**	**NO_____**
Billing information	**YES_____**	**NO_____**
Medical information	**YES_____**	**NO_____**

My signature verifies that I have read and understood this form.

Patient Signature_____ Date: _____

Patient Name: _____
PLEASE PRINT

THIS NOTICE MAY BE CHANGED BY WRITTEN REQUEST AT ANY TIME