NARASIMHAN
PLASTIC SURGERY

Narasimhan Plastic Surgery

Protected Health Information Consent

Recipient Authorization to Use or Disclose Protected Health Information

PATIENT RECORDS OF DISCLOSURES

Patient Name: _____ **DOB:** _____

Thank you for choosing Narasimhan Plastic Surgery for your care. We value you as our patient and honor your privacy.

In general, the HIPAA privacy rule gives individuals the right on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that communication of PHI be made by alternate means, such as sending correspondence to the individual's office instead of the individual's home.

In an effort to maintain the confidentiality of your visit and any future visits, please take a moment to fill out the requested information. The information provided by you will be added to your electronic medical record stating your communication preferences. If at any time you wish to change your preferences, please contact our office and we will send you a new form to update your record.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone_____

- ☐ Authorized to leave a message with detailed information
- ☐ Authorized to leave a message with call-back number only

☐ Work Telephone_____

- ☐ Authorized to leave a message with detailed information
- ☐ Authorized to leave a message with call-back number only

☐ Mobile Telephone_____

- ☐ Authorized to leave a message with detailed information
- ☐ Authorized to leave a message with call-back number only

Patient Name: _____ **DOB:** _____

☐ Written communication

☐ Authorized to mail to my home address

☐ Authorized to mail to other address

_____

_____

☐ Authorized to fax to this number _____

☐ Pharmacy Name and Number: _____

☐ Staff may talk with:

Name:_____

Relationship: _____

~SIGNATURE REQUIRED ~

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and request for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

I have read/received the notice of Privacy Practices Acknowledgment and been provided the opportunity to review this disclosure.

Name: _____

Signature:_____ **Date:**_____

FEDERAL LAW REQUIRES THAT WE HAVE THIS CONSENT IN EVERY PATIENT CHART