HIPAA Compliance Requirements

The Center for Facial Plastic Surgery is required by law to maintain the privacy of our patients and to provide each individual with this notice with respect to protected health information. If you have any concerns or objections to this form, please ask a staff member for further details about HIPAA compliance requirements.

I request that my *Protected Health Information* be discussed with and released to the parties that I designate below: (select all that apply)

- ___ Parents or Legal Guardian
- ___ Spouse
- ___ Other Family Members(s)
  Please list: _____
- ___ Other person(s)
  Please list: _____
- ___ My Protected Health Information (PHI) is to be discussed with me only.

May we have permission to leave messages on your voicemail?

___ Yes ___ No

May we have permission to mail paperwork to the address that you provide?

___ Yes ___ No

May we have permission to email information to the email that you provide?

___ Yes ___ No

Print Name: _____

Signature: _____ Date: _____