

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: _____