



PERSONS PLASTIC SURGERY

**Barbara Persons M.D.  
Cosmetic & Reconstructive Surgery Center**

**HIPPA Form 1**

**CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION**

**SECTION A: PATIENT GIVING CONSENT**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ D.O.B: \_\_\_\_\_

**SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.**

**Purpose of Consent:** by signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our Privacy Practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

**Contact Person: Katie Hoppe**

**Telephone: (925) 283-4012 Fax: (925) 283-4847**

**E-mail: [info@personsplasticsurgery.com](mailto:info@personsplasticsurgery.com)**

**Address: 911 Moraga Road, Suite 205, Lafayette, CA. 94549**

**Right to revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

**SIGNATURE SECTION – PLEASE PRINT**

I, \_\_\_\_\_, have had full opportunity to read and consider the consents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_



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**HIPPA Form 2**

**HIPPA – ACKNOWLEDGEMENT OF RECEIPT OF NOTICE  
OF PRIVACY PRACTICES**

**\*\*You May Refuse to Sign This Acknowledgement\*\***

I, \_\_\_\_\_, (please print your full legal name) have been shown the Privacy Policy for this Office, and have been offered a copy of such policy to keep for my records.

I hereby give permission for this Office to leave messages on the answering service / voicemail / text messaging at

- My Home (please initial)\_\_\_\_\_
- My cell phone (please initial)\_\_\_\_\_
- My office (please initial)\_\_\_\_\_

I hereby give the following people permission to receive information from this Office on my behalf:

_____ Name of Person	_____ Relationship to me (e.g., mother, friend, spouse)
_____ Name of Person	_____ Relationship to me
_____ Name of Person	_____ Relationship to me
_____ {Signature}	_____ {Date}

**For Office Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- An emergency situation prevented us from Obtaining acknowledgement
- Communication barriers prohibited Obtaining the acknowledgement
- Other (Please Specify)

_____ {Employee Signature}	_____ {Date}
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