CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Your protected health information will be used by Dr. David Stoker, a board-certified Diplomate of the American Board of Plastic Surgery or disclosed to others for the purposes of treatment, obtaining payment or supporting the day-to-day health care operations of the practice.

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent form.

You may request a restriction on the use or disclosure of your protected health information. Dr. Stoker may not agree to restrict the use of disclosure of your protected health information. If Dr. Stoker agrees to your request, the restrictions will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards. You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use of disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected. Dr. Stoker reserves the right to modify the privacy practice outline in the notice.

I, _____ hereby request the use of the following confidential channels for the communication of information related to my personal health or treatment. This request supersedes any prior request for confidential channel communications I have made.

May we use telephone number (s) and your email address to contact you? Yes No

If not, what telephone number (s) and email address (es) may we use?

_____

May we discuss pertinent information with anyone else? Yes No
If yes, please state name and relationship to you.

Name _____Relationship _____

Name_____ Relationship _____

Name _____Relationship _____

SIGNATURE

I received a copy of the office privacy practices and have reviewed this consent form and give my permission to Dr. Stoker to use and disclose my health information in accordance with it.

_____

Name of Patient (please print)

_____

Signature of Patient Date