Cosmetic Surgery
OF NEW YORK PC

HIPAA - PATIENT PRIVACY NOTICE

Authorization for Use and Disclosure of Private Health Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below.

Patient Name:_________________________________ ID#_________________________

Name of person or entity, or category of persons/entities, to whom the use or disclosure may be made: Patients Insurance Carrier, Subpoena from Court, Record Releases to another Physician, and Patient's School.

The following information will be included in disclosure: any pertinent medical history, office visits, notes.

This protected health information is being used or disclosed for the following purposes: Chart reviews done by Patients Insurance Carrier, Transfer of records to new Doctor, Legal Matters relating to the patient, Consultations with Medical Specialist in the care and well being of the patient.

This authorization shall be in force and effect until December 31, 2015.

I understand that I have the right to receive a copy of Privacy Policy in place for Cosmetic Surgery of New York, P.C. by requesting a copy from office.

I understand that Cosmetic Surgery of New York, P.C. will not condition my treatment on whether I provide authorization for the requested use or disclosure if to do so would be prohibited by federal or state law. If a reason exists under law for conditioning my treatment on obtaining this authorization, I have been advised of the fact and of the consequences to me of refusing to sign this authorization.

I understand that there is a potential for information used or disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer be protected by federal or state law.

No authorization is being requested for marketing purposes.

This authorization will be placed in patient's chart.

** **Please note:** Examinations performed at Cosmetic Surgery of New York, P.C. are for purposes of evaluation for cosmetic surgery only. Examinations performed for evaluation for cosmetic surgery of not a substitute for routine medical care.

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Signature of Patient, Parent or Guardian Date

4616 Nesconset Highway, Port Jefferson Station, NY 11776
Phone: 631-473-7070 | info@cosmeticsurgeryofny.com | Fax: 631-331-2654