esse
plastic surgery
dr. tracey stokes

HIPPA Consent To Release Medical Information

I understand, under the HIPPA (Health Portability and Accountability Act) of 1996, that I have certain rights regarding the protection of my health information. I understand this information can and will be used for the following:

The conduct, plan and direct treatment and follow up among various healthcare professionals directly or indirectly involved in my treatment; to obtain claim status or payment from insurance companies or any third party payer; or to perform administrative procedures including quality assessment or physician certification.

In addition, I will also allow messages to be left on my voicemail regarding my health information (i.e. test results) and future appointment confirmations or changes.

I have been informed and given the right to review the offices Notice of Privacy Practices that describes a more complete description of the uses and disclosures of my health information.

I am aware and understand that I may submit a written request to this office restricting the use and disclosure of my health information to carry out any release listed above or in the Notice of Privacy Practices. I also understand the office does not have to agree to restrictions, but if agreed, the office is bound to my restrictions.

By my signature, I hereby acknowledge receipt and understanding of this form.

_____ _____

Witness Signature Patient/Agent/Guardian Signature

_____

Date