

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Bal Harbour Plastic Surgery Associates/Michael Salzhauer, M.D., P.A. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Bal Harbour Plastic Surgery Associates/Michael Salzhauer, M.D., P.A. I understand that diagnosis or treatment of me by Dr. Salzhauer may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Bal Harbour Plastic Surgery Associates/Michael Salzhauer, M.D., P.A. is not required to agree to the restrictions that I may request. However, if Bal Harbour Plastic Surgery Associates/Michael Salzhauer, M.D., P.A. agrees to a restriction that I request, the restriction is binding on Bal Harbour Plastic Surgery Associates/Michael Salzhauer, M.D., P.A. I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Salzhauer or Bal Harbour Plastic Surgery Associates/Michael Salzhauer, M.D., P.A. has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Bal Harbour Plastic Surgery Associates/Michael Salzhauer, M.D., P.A.'s Notice of Privacy Practices prior to signing this document. The Bal Harbour Plastic Surgery Associates/Michael Salzhauer, M.D., P.A.'s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Bal Harbour Plastic Surgery Associates/Michael Salzhauer, M.D., P.A.. The Notice of Privacy Practices for Bal Harbour Plastic Surgery Associates/Michael Salzhauer, M.D., P.A. is also provided at the offices located at 9801 Collins Avenue, Bal Harbour, Florida. This Notice of Privacy Practices also describes my rights and the Bal Harbour Plastic Surgery Associates/Michael Salzhauer, M.D., P.A.'s duties with respect to my protected health information.

Bal Harbour Plastic Surgery Associates/Michael Salzhauer, M.D., P.A. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting that a revised copy be sent in the mail or by asking for one at the time of my next appointment.

I hereby grant permission for the use of any of my medical records, illustrations, photographs, or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc.

Signature of Patient or Personal Representative

Date

Print Name of Patient or Personal Representative

Description of Personal Representative
Authority

Print Name of Witness

Signature of Witness