ACKNOWLEDGMENT AND CONSENT

I understand that Combs Plastic Surgery & Aesthetics (referred to below as "CPSA") will use and disclose health information about me.

I understand that my health information may include information both created and received by CPSA, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnosis, treatments, procedures, prescriptions and similar types of health-related information.

I understand and agree that CPSA may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- Determine my eligibility for health plan or insurance coverage, submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care;
- Perform various office, administrative and business functions that support my physician's efforts to provide me with , arrange and be reimbursed for quality, cost effective health care.

I also understand that I have the right to receive and review a written description of how CPSA will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information and the information practices followed by the employees, staff and other office personnel of CPSA, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a summary of the most current version the CPSA's Notice of Privacy Practices in effect is available to me upon request.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that CPSA is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and have been offered a copy of the Notice of Privacy Practices.

Patient:_____ Date: _____

(Patient Representative)_____(Rep's Authority)_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize CPSA to discuss information related to my care with:

Name_____Relationship_____

Name_____Relationship_____