c h i c a g o
COSMETIC SURGERY AND DERMATOLOGY

Name: «Person_First_Name» «Person_Last_Name»
Patient ID: «Person_ID»

RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT FOR RELEASE AND USE OF CONFIDENTIAL INFORMATION
Effective date January 1, 2016

I am a patient of Chicago Cosmetic Surgery and Dermatology, SC. I hereby acknowledge that I have received, understand and consent to this practice's Notice of Privacy Practices as written. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information. I understand that Chicago Cosmetic Surgery and Dermatology, SC has reserved the right to change the terms of its Notice of Privacy Practices. If changes to the policy do occur, this practice will provide me with a revised Notice of Privacy Practices upon my request.

I ACKNOWLEDGE AND AGREE THAT NO AMENDMENT TO THIS FORM IS PERMITTED. I MAY REQUEST AMENDMENTS TO MY MEDICAL RECORDS IN ACCORDANCE WITH STATE AND FEDERAL LAW AND REGULATION.

With this consent, Chicago Cosmetic Surgery and Dermatology, SC, or our agents may call my home, cell or other alternative locations and leave a message on voicemail or in person, including but not limited to, appointment reminders, billing items and any calls pertaining to my care.

_____ _____
Signature of Patient or Authorized Agent Date

I am a parent or legal guardian of «Person_First_Name» «Person_Last_Name». I hereby acknowledge receipt of Chicago Cosmetic Surgery and Dermatology, SC's Notice of Privacy Practices with respect to the patient.

Name [please print]: _____Relationship _____

Signature:_____Date: _____

Family and Friends: It is the office policy of Chicago Cosmetic Surgery and Dermatology, SC *not* to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). **If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/guardians, please indicate below, so that we may best serve you.** By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add names in the future please confirm this in writing).

Name [please print]: _____Relationship _____

Name [please print]: _____Relationship _____

Name [please print]: _____Relationship _____