Murphy PLASTIC SURGERY
DEFINING EXCELLENCE

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain healthcare providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment or healthcare operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your healthcare information and information about treatment, payment or healthcare operations, in order to provide healthcare that is in your best interest. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment or healthcare operations. This includes but is not limited to business associates such as the anesthesia or billing services. Under certain circumstances we may use and disclose health information for research that Dr. Murphy is involved in.

We also want you to know that we support your full access to your personal medical records. All requests for medical records must be made in writing and signed by you whether for use by yourself, another doctor or any other persons. To protect your privacy medical records and photographs will never be sent out in electronic form.

You have the right to be notified if a there is a breach of any of your Protected Health Information. You have a right to request a list of entities we have given your health information to.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse treatment, should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this consent.

If you have any objections to this form or need to report a violation of the Privacy Rule, please ask to speak with the office manager our HIPAA Compliance Officer.

Please list any nonmedical person(s) to whom we may disclose your Personal Health Information for medical care and payment of your care, in the event that it becomes necessary. These names may be changed by you in writing at any time.

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Print Name _____ Signature _____ Date _____