SIEVEKING
PLASTIC SURGERY

HIPAA PATIENT PRIVACY POLICY

All patients have the right to review our Notice of Privacy Practices below. If you would like to restrict access or to request modifications be made to your personal health information, please request the required form from a member of our staff. Any member of our staff may use telephone or fax to contact your insurance company, physician or pharmacy to release your personal health information, photos, etc. , as needed for treatment, payment and health operations.

Limitations of Practice: I understand that Sieveking Plastic Surgery is limited to Plastic and Reconstructive Surgery, as well as Cosmetic Laser and Skin Care.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessment and physician certifications.

I received, read and understand the Notice of Privacy Practices containing a more complete description of the uses and disclosure of my PHI. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

PATIENT NAME or LEGAL GUARDIAN (PRINT) _____

_____ _____

Patient Signature Date

FOR PRACTICE USE ONLY:

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so. See documentation below:

Date: _____ Initals: _____ Reason:

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