AUSTIN PLASTIC SURGERY INSTITUTE
& SKIN CARE CLINIC

NOTICE OF HEALTH INFORMATION PRACTICES ACKNOWLEDGEMENT FORM AND RELEASE OF INFORMATION

The attached notice describes how medical information about you may be disclosed and how you can get access to this information. Please sign this cover sheet acknowledging receipt of the policy and return it to the receptionist. Review the policy carefully and let us know if you have any questions or requests.

By my signature below, I acknowledge that I have received the Notice of Health Information Practices of _____.
I understand that the organization (APSI) reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address that I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already acted in reliance thereon.

I AUTHORIZE APSI T O DISCLOSE MY PROTECTED HEALTH INFORMATION TO:

_____
Person/Organization Name

_____
Address, City, State, Zip Code

_____
Phone

_____

Fax _____

_____
Name of Patient

_____
Signature of Patient

AUSTIN PLASTIC SURGERY INSTITUTE
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Date