Madison Plastic Surgery, P.C.

Plastic & Reconstructive Surgery

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We will obtain a one-time general written consent to use and disclose your health information in order to treat you, obtain payment of that treatment, and conduct our business operations. This general consent is a broad permission that does not have to be repeated each time we provide treatment or services to you.

We will generally obtain your written authorization before using your health information or sharing it with other outside our practice. You may ask that we transfer your records to an outside physician by filling out a written authorization at any time, except to the extent that we have already replied upon it or take action to do what you have asked us to do. To revoke a written authorization please contact Madison Plastic Surgery, P.C., 46 East 82nd Street, New York, N.Y. 10028

My signature below indicated that I have been provided with a copy of the Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the physician private practice: Madison Plastic Surgery, P.C.

Finally, by signing below I consent to the use and disclosure of my health record in order to treat me and arrange for my medical care, to seek and receive payment for services given to me and for the business operations for this practice, its physician and staff.

____________________________________ ____________________
Signature of Patient or Legal Representative Date

If signed by legal representative, relationship to patient ____________________________