FacesFirst
COSMETIC SURGERY
A division of Associates of Otolaryngology P.C.

Consent Policy

I consent to the use of disclosure of my protected health information by **FacesFirst** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **FacesFirst**. I understand that diagnosis or treatment of myself by a **FacesFirst** provider may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **FacesFirst** is not required to agree to the restrictions that I may request.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, and health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is reasonable basis to believe the information may identify me.

I understand I have a right to review **FacesFirst** Notice of Privacy Practices prior to signing this document. The **FacesFirst** Notice of Privacy practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the **FacesFirst**. The Notice of Privacy Practices for **FacesFirst** are provided at 850 E Harvard Ave. Ste. 575 Denver, CO 80210 and/or 9218 Kimmer Dr. Ste. 202 Lonetree, CO 80124, or on the **FacesFirst** website at www.facesfirst.com. This Notice of Privacy Practices also describes any rights and the **FacesFirst** duties with respect to my protected health information.

FacesFirst reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. You may obtain a revised notice of privacy practices by accessing the **FacesFirst** website, calling the office and requesting a revised copy be sent in the mail, or asking for one at the time of your next appointment. I acknowledge I have read the above information and agree to adhere to the terms of the policies.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Name of Patient or Personal Representative Personal Representatives Authority

Name of person who is ok to receive my information:	**Release Info**		**Leave Message**		**Ok to Email**	
_____	Yes	No	Yes	No	Yes	No
_____	Yes	No	Yes	No	Yes	No

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