

Health Care Disclosure Notification

Dear Patient:

Effective April 14, 2003, the Federal Health Privacy Rule must be implemented and we must inform our patients of their rights under this law.

While we have always made every effort to keep all your information confidential, we are now required to inform you of those persons or entities who may have access to your personal and health care information.

- 1) Employees of CosmetiCare and South Coast Outpatient Surgery Center (limited by job classification)
- 2) Physicians associated with your treatment or surgical procedure
- 3) Outside physicians or pathologist who would examine tissue removed
- 4) Anesthesiologist associated with the Surgery Center
- 5) Any physician or hospital to whom you are referred by our staff physicians
- 6) Any independent contractor working with CosmetiCare, i.e. consultants and aestheticians
- 7) Any independent contractor working with South Coast Outpatient Surgery Center, i.e. registered and licensed vocational nurses and technologists.
- 8) Your health insurance provider
- 9) Designated family members or friends (post surgical)
- 10) Accrediting agencies
- 11) Medical staff committees for the purpose of quality assessment and peer review
- 12) Licensing agencies in response to inquiries
- 13) Issuance of a subpoena and upon verification of authorization
- 14) Research-patients who are participating in a clinical study

ALL PATENTS WILL BE REQUESTED TO SIGN A CONSENT PRIOR TO TREATMENT.

Patient's Rights

1. Patient has the right not to sign consent. However, this would necessitate the physician to refuse treatment.
2. A patient has the right to revoke the consent after receiving treatment.
3. Patient has the right to request restrictions and request confidential communication.
4. Patient has the right to examine and review his or her health information upon written request. This request will be honored within five (5) working days.
5. Patient has the right to request a copy of his or her health information upon written request. The copy will be completed within 15 days of receiving request at a cost to the patient of \$ 0.25 per page.

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6. Patients have the right to request an amendment to their health information and, if accepted, this will become a part of the complete medical record. Information and procedure to be followed can be received by contacting April Lee at extension 255.

7. Patients who feel their privacy with regards to personal or health care information has been compromised may contact:

- a) April Lee, in this office, at extension 255
- b) Department of Health and Human Services
- c) Office of Civil Rights

NOTICE: By signing this notification you are agreeing that you have been notified of the Federal Health Privacy Rule now in effect.

Patient Name (Print)

Date

Signature: Patient or Patient's Representative

**CONSENT FOR THE DISCLOSURE
OF HEALTH AND PERSONAL INFORMATION**

You have already received our Disclosure Notification, which made you aware of the persons and entities whom could possibly have access to your medical information for the purposes of treatment, payment and health care operations.

As stated in the Notification, you have the right to request restrictions or revoke your consent, If you have any further questions or need clarification, please discuss with a member of our staff.

I consent for the use of my medical personal information to be used for the purposes outlined in the Disclosure Notification.

I have restrictions: Yes No _____ Initial

Please list any restrictions below:

Restrictions Approved by Provider: Yes No _____ Initial

I have read and understand the foregoing Consent for Disclosure.

Patient's Name _____ Date _____

Patient or Patient's Representative
Signature _____ Date _____