HIPAA Authorization for Use or Disclosure of Health Care Information

Cesar A. Sierra, M.D.
Ophthalmic Facial Plastic Surgery
(203) 226-1696

SECTION A: PATIENT GIVING CONSENT

Name:_____

Home Address:_____

Telephone Number:_____

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to the use and disclosure of your protected health information to carry out our treatment, payment activities, photographs and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

I understand that I have the right to revoke this Consent, in writing, at any time, except (1) where uses or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by permission cannot be taken back. To revoke this Consent, I must do so in writing and send to: **Cesar A. Sierra, M.D., Ophthalmic Facial Plastic Surgery, 125 Kings Highway North, Westport, Connecticut 06880.**

PLEASE PRINT FULL NAME AND SIGN BELOW:
I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____ **Date:**_____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:_____

Relationship to Patient:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT
Include completed Consent in patient's chart.