



CONSENT FOR PURPOSE OF TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

**Audrey E. Farahmand MD**

I consent to the use or disclosure of my protected health information by **Farahmand Plastic Surgery** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Farahmand Plastic Surgery's** practice.

I understand that diagnosis or treatment of me by **Farahmand Plastic Surgery** may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have a right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations. Dr. Farahmand is not required to agree to the restrictions that I may request. However, if Dr. Farahmand agrees to a restriction that I request, the restriction is binding on Dr. Farahmand's practice and on Dr. Farahmand.

I have the right to revoke the Consent, in writing, at any time, except to the extent that Dr. Farahmand's practice has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information collected from me and collected or received by my physician, another health care provider, a 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 a reasonable basis to believe the information may identify me.

I understand I have a right to review **Farahmand Plastic Surgery's** Notice of Privacy Practices prior to signing this document.

**Farahmand Plastic Surgery's** Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices for the **Farahmand Plastic Surgery** practice describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or the performances of Dr. Farahmand health care operations.

A summary of the Notice of Privacy Practices for **Farahmand Plastic Surgery** is also posted in the waiting room.

This Notice of Privacy Practices also describes my rights and the duties of the **Farahmand Plastic Surgery** practice with respect to my protected health information.

**Farahmand Plastic Surgery** reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised Notice of Privacy Practices by contacting Dr. Farahmand's office at 13710 Metropolis Avenue Unit #104, Fort Myers , Florida 33912 or call (239) 332-2388.

\_\_\_\_\_  
**Name or Patient (please print)**

\_\_\_\_\_  
**Signature of Patient or Representative**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**Employee Signature**