Summit
MEDICAL SPECIALISTS

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AESTHETICS
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USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION AGREEMENT

This disclosure contains information regarding the privacy of your personal healthcare information. Please read it carefully before signing. Summit Medical Specialists will not condition treatment by your failure to sign this disclosure.

By signing this disclosure, I acknowledge that Summit Medical Specialists may use or disclose my medical information for the purpose of my treatment or obtaining payment for services rendered. I am aware that Summit Medical Specialists may disclose my medical information to a Business Associate for the same reasons, and that the Business Associate will be bound by all appropriate legal restrictions.

Further, by signing this document I acknowledge that I have been provided a copy of and have read the Notice of Privacy Practices containing a complete description of my rights, and the permitted uses and disclosure, under HIPAA.

Please list daytime telephone number(s) at which you prefer to be reached.

_____ _____

Acknowledged and agreed to by:

Patient:_____ **or Representative:**_____

Signature:_____ **Date:**_____

The Federal Government now restricts Summit Medical Specialists from discussing your health information and condition with other family members or person unless you specifically give your written permission.

By my signature below, I grant Summit Medical Specialists permission to discuss my protected medical information with the following individuals:

_____ _____
Name Relationship

_____ _____
Name Relationship

Signature of Patient:_____ **Date**_____