HIPAA Privacy Practices

I understand that Elisa A. Burgess, MD, PC (referred to below as "This Practice") will protect and not use my personal health information when the purpose does not directly relate to my care without my permission.

I understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health and similar types of health-related information.

You have the right to restrict how your personal health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of information for treatment, payment, or healthcare operations.

I understand and agree that This Practice may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment.
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care treatment.
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims, and other related information to insurance companies or other who may be responsible to pay for some or all of my healthcare; and
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange, and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and that information practices followed by the employee, staff, and other personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices in effect will be posted in waiting/reception area.
I understand that I have the right to ask that some or all my health information not be used or disclosed in the manner described in The Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

Patient/Guardian Signature_____ Date_____

If you would like a copy of the entire Notice of Privacy Practices, please refer to our website:
www.BurgessPlasticSurgery.com/Patient-Resources/Patient-Forms/