Herrera Health Services
Aryeh L. Herrera, M.D., F.A.C.S.

ARYEH L. HERRERA, M.D., F.A.C.S.
BOARD CERTIFIED
PLASTIC & RECONSTRUCTIVE SURGERY

GENERAL RECONSTRUCTION
MICROVASCULAR SURGERY
MAXILLOFACIAL SURGERY
HEAD AND NECK CANCER
COSMETIC SURGERY
BREAST SURGERY
HAND SURGERY
WOUND CARE

Notice of Privacy Practices and Consent

The Patient hereby consents to the use or disclosure of his/her individually protected health information by Allegheny Plastic Surgery in order to carry out treatment, payment, or health care operations. The Patient should review the Facility's Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information, and the Patient has the right to review such Notice prior to signing this consent form.

Facility reserves for itself the right to change the terms of its Notice of Privacy Practices for Protected Health Information at any time. If the Facility does change the terms of its Notice of Privacy Practices, we will post a summary of the current notice in our office with the effective date. You are entitled to a paper copy upon request.

Patient retains the right to request that the Facility further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Facility is not required to agree to such requested restrictions; however, if the Facility does agree to Patient's requested restriction(s), such restrictions are then binding on the Facility.

At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to the Facility in writing. The revocation shall be effective *except* to the extent that the Facility has already taken action in reliance on the Consent

As required by law **Allegheny Plastic Surgery** has provided you with Notice of Privacy Practices. This notice describes information about privacy practices followed by our health care providers, employees, staff and other office personnel. It also describes your rights and obligations in which information and records that we may have about your health, health status and the healthcare and services you receive at this office may be used or disclosed**.**

I HAVE READ AND UNDERSTAND THIS INFORMATION. I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS SEALED DOCUMENT VERIFYING RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT TO THE ABOVE STATED TERMS.

_____	_____	_____
Patient Signature	Date	Please Print Name
_____	_____	_____
Parent Signature	Date	Please Print Name

324 ANTIETAM STREET, SUITE 306B
HAGERSTOWN, MARYLAND 21740
301-739-7790 • FAX (301) 739-4093

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Please explain Representative's relationship to the Patient and include a description of Representative's Authority to act on behalf of the Patient.

_____

_____

_____

_____	_____	_____
Witness Signature	Date	Patient's Chart Number

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