PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I hereby give my consent for Cumberland Plastic Surgery, P.C., Dr. John David Rosdeutscher, M.D., and staff to use and disclose **Protected Healthcare Information** (PHI) about me to carry out **Treatment**, **Payment** and **Other** health care operations (TPO). Cumberland Plastic Surgery's Notice of Privacy Practices provides a more complete description of such uses and disclosures; I have the right to review the Notice of Privacy Practices prior to signing this consent.

I (circle one) **DO / DO NOT** want to receive a copy of Dr. John David Rosdeutscher's Notice of Privacy Practices.

With this consent Cumberland Plastic Surgery, and Dr. John David Rosdeutscher, may call my home or other alternative locations regarding any items that assist the practice in carrying out treatment, payment and other healthcare options. This includes appointment reminders, patient statements, and any calls pertaining to my clinical care. I have the right to request that Cumberland Plastic Surgery, John David Rosdeutscher, M.D. restrict how it uses or discloses my protected healthcare information to carry out treatment, payment, and other healthcare options. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Cumberland Plastic Surgery, P.C., and John David Rosdeutscher, M.D. to use and disclose my protected healthcare information in the course of my treatments. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Cumberland Plastic Surgery, and John David Rosdeutscher, M.D. may decline to provide treatment to me.

Due to patient confidentiality laws it is impossible for our office to share your medical information with your immediate family members unless you instruct us otherwise. Please fill out the information below if there is anyone that you would like us to share your information with.

If no one is listed below we will not give any of your information to anyone but you.

Name: _____ Relationship: _____

Phone Number: _____

Name: _____ Relationship: _____

Phone Number: _____

_____

Patient/Guardian Signature Date