BEVERLY FISCHER, MD
THE ADVANCED CENTER FOR PLASTIC SURGERY
(410) 308-4700

This notice describes how medical information about you may be used and disclosed. We are required by law to protect the privacy of your protected health information. This document also explains how you can gain access to your medical information and who to contact should you have any complaint. Please read the document carefully and sign the bottom of the form to acknowledge that you have received it.

A. The general consent for release of medical records that you sign authorizes Advanced Center for Plastic Surgery to disclose the information in your medical record for treatment, payment and health care operations:

   1. For the purpose of providing treatment to you. Your information may be shared with e.g. employees and contractors of the provider, or with other healthcare providers who are treating you or consulting in your care.
   2. For the purpose of arranging payment for your care. Your information may be shared with your insurer or other third-party payer who is responsible for paying all or part of the cost for your care.
   3. For the purpose of health care operations. We may use and disclose information that is necessary for our operations e.g. internal quality assessments, contacting other health care providers about treatment alternatives. We may also disclose information to doctors, nurses, technicians or other practice personnel who are involved in your medical care and treatment. Different areas of the practice also may share medical information about you in order to coordinate the different things you need, such as prescriptions and lab work. We may also disclose medical information about you to people outside the practice who may be involved in your medical care after you leave our office, such as family members or others we may rely upon or ask to assist us in caring for you. We may use information about you to provide you with appointment reminders such as voicemail messages, postcards or letters.

Please provide the name and phone number of a family member or friend that is permitted to receive messages/mail from our office pertaining to you in the event that we can not get touch with you:

NAME (FAMILY MEMBER OR FRIEND) PHONE NUMBER

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B. You may be asked to sign a specific authorization for release of medical records, which will authorize us to make a specific disclosure that is not covered under Section A above. The specific information, the entity to whom it will be disclosed, and the purpose for which it will be used will be documented for your review before signing.

C. You may revoke any consent or authorization provided to us by giving a written notice of revocation.

D. We may be required by law to disclose your records that you have not authorized. For example if we receive a subpoena for the records. We will keep all disclosure of your medical records to the minimum necessary.

E. Your rights regarding health information about you:

1. You have the right to inspect and copy your health information.
2. If you feel that the health information we have about you is incomplete or inaccurate you have the right to request an amendment to your medical records. The request must be made in writing with the reason that supports your request.
3. You have the right to find out how your health information is used and to whom it is disclosed. You may request an accounting of your medical records disclosures made by us except for disclosures made for treatment, payment and health care operations.
4. You have the right to receive a paper copy of this notice.

F. We are required by law to maintain the privacy of your protected health information and if you believe that your rights have been violated you may complain to the Secretary of The U.S. Department of Health and Human Services or complain to us by talking to us, calling us, or writing us with details. Please ask to speak to our Office Manager who is our Privacy Contact person.

G. If you have an advanced directive, please provide us a copy. If you need additional information on advanced directives, please visit www.Medicare.gov and search advanced directives.

H. When necessary, these policies will be modified to ensure compliance with practice operations and with State and Federal privacy regulations.

Please acknowledge receipt and review of this notice by signing below.

SIGNATURE OF PATIENT OR LAWFULLY AUTHORIZED PERSON DATE