

**KEVITCH
CHUNG & JAN**
AESTHETIC SURGERY ASSOCIATES

PLASTIC SURGERY & DERMATOLOGY

250 Cetronia Road, Suite 301/302, Allentown, PA 18104
(P) 610-437-2378 / (F) 610-820-9983

HIPAA Communication Form

Name: _____ **Date of Birth:** ____/____/____

Preferred Name: _____

I authorize the release of information including appointment confirmation and the diagnosis, records; examination rendered to me and claims information. The information may be released to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

INFORMATION MAY NOT BE RELEASED TO ANYONE

The release of this information will remain in effect until terminated by me in writing.

Phone Calls/Messages

Please Call or Text: Home Phone Cell Phone Work Phone

Opt **Out** Of Text Message Confirmation

If Unable to Reach Me: You may leave a detailed message

Please leave a message asking me to return your call

Email Specials: Opt Out I authorize specials to be sent via Email

Email Address: _____

Patient medical information may be used by the person/medical facility I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct without me challenging any type of payment once services are provided. I acknowledge that I have received the Notice of Privacy Practice for Aesthetic Surgery Associates which is under current HIPAA Omnibus Rule.

Print Name of Patient or Legal Guardian

Signature of Patient or Legal Guardian

Date

OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's (or representative's) signature on this form but did not because:

- It was emergency treatment
- I could not communicate with the patient
- The patient refused to sign
- The patient was unable to sign
- Other: _____

Privacy Officer Signature: _____