AESTHETIC SURGERY ASSOCIATES
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: _____