MORGENSTERN CENTER
for Orbital and Facial Plastic Surgery
123 BLOOMINGDALE AVENUE, WAYNE, PA 19087-4056

Office: (610) 687-8771 Fax: (610) 687-8773 www.MorgensternCenter.com

PRIVACY PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights second describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Morgenstern Center provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Morgenstern Center has a Summary Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Morgenstern Center reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but The Morgenstern Center does not have to agree to those restrictions. Any restrictions will be reviewed by our HIPAA Compliance Committee and the patient will be notified of their final decision.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease. Requests will be forwarded to the Morgenstern Center HIPAA Compliance Committee.
- The Morgenstern Center may condition treatment upon the execution of the Consent.

I give the Morgenstern Center permission to communicate with _____
in regards to my Private Healthcare Information **(Name and Relationship)**

Signed by: _____

Printed Patient Name: _____

This Consent was signed by: Patient or Representative (Please circle one)

_____ (If other than patient, Relationship)

In front of _____ **Date**: _____
(Morgenstern Center employee)

Patient refuses to sign._____ Reason: _____