METAMORPHOSIS
PLASTIC SURGERY
9171 Baltimore National Pike, Ste 205
Ellicott City, MD 21042
Phone: 410-465-3600
Email: Info@DiscoverTheBeauty.com

HIPPA NOTICE OF PRIVACY PRACTICES – *Effective April 14, 2003*

I, _____, have been presented with the Notice of Privacy Practices detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

My protected health information is individually identifiable health information, including demographic information collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse, and relates to: (i) my past, present, or future physical or mental health condition; (ii) the provision of the health care to me; or (iii) the past, present or future payment for the provision of health care to me. In accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA), I, the undersigned, grant permission to Metamorphosis Plastic Surgery, LLC. to disclose protected health information (as defined in HIPAA) to the following person or persons:_____
_____.

Purpose of authorization: ☐At my request ☐Family member assisting with health care
☐Other: _____

Any limitations that I impose on Metamorphosis Plastic Surgery, LLC with respect to this authorization are declared below:
_____

In addition, I may revoke this Release at any time by notifying Metamorphosis Plastic Surgery of the revocation in writing and faxed to 410-465-3960, Attn: Office Manager. If at any time you need to alter this release form, please contact Metamorphosis Plastic Surgery at 410-465-3600.

Print Patient Name: _____

Patient Signature: _____ Date_____

Internal Use Only:

If patient or patient representative refuses to sign acknowledgement, please document date and time the notice was presented to the patient and sign below.

Presented on (date and time) _____

By (name and title) _____