



Cosmetic Surgery Clinics

Health Insurance Portability and Accountability Act of 1996
Policy to Protect Patient Privacy

Notification is hereby given that Cosmetic Surgery Clinics will not reveal any personal information about you or your dependent(s) without your permission. Your information will never be sold or listed for the purpose of advertisement, solicitation or fundraising.

It is, however, understood that within the realm of doing business and for general patient care, your personal information will be necessary and used in the following context.

- Patient registration
- Procure medical records from former physicians
- Converse with colleagues for opinions/care
- Insurance: verification, billing, paper and wire (including fax transmissions), Insurance company follow up or interaction with billing services
- Pursue collection of unpaid bills
- Office staff, nurses, physicians
- Emergency officials, paramedic and fire personnel, emergency room physicians, nurses or technicians
- Personal religious designate
- Pharmacists, pharmacy staff
- Completion of disability forms
- Computer and electronically stored information (i.e. related business vendor and service personnel)

I authorize the release of this necessary information.

Patient(or Parent) Signature

Date



Cosmetic Surgery Clinics

Receipt of Notice of Privacy Practices Written Acknowledgement Form

Arian Mowlavi, M.D.

The undersigned hereby acknowledges that he/she has reviewed a copy of Dr. Mowlavi’s Privacy Practices.

I, _____, have reviewed a copy of Dr. Mowlavi’s Notice of Privacy Practices. I will indicate below my preference for communication with this office:

- I would like to have a copy of the Notice of Privacy Practices
- I would not like to have a copy of the Notice of Privacy Practices
- I would like you to call me at **home** for confirmation / results / other
 - Leave message **Do not** leave message Home: () _____
- I would like you to call me at **work** for confirmation / results / other
 - Leave message **Do not** leave message Work: () _____
- I would like you to call me on my **cell** for confirmation / results / other
 - Leave message **Do not** leave message Cell: () _____
- I would like you to communicate with me via **email** regarding any non-emergency medical issues. **My email address is:** _____.

I give my permission for Dr. Mowlavi to discuss my medical condition with:

Name	Relation	Phone number

Further, I understand that Dr. Mowlavi and his staff will be contacting me by using the telephone numbers that I provide to this office – either by telephone, by writing, or in person which may be in addition to those I have listed above. As the patient I am aware that it is my sole responsibility to inform the office of any telephone number changes. I will do so by telephone and / or at the time of check in for my appointments.

Patient Signature
(HIPAA Consent Feb 06)

Date