NOTICE OF PRIVACY FOR
PROTECTED HEALTH INFORMATION

Date: _____

BY SIGNING THIS DOCUMENT, I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF PINNACLE PLASTIC SURGERY ASSOCIATES, LLC NOTICE OF PRIVACY PRACTICES.

I hereby give my consent for Pinnacle Plastic Surgery Associates, LLC to release my protected health information to the following family member and/or friend in the case of an emergency:

Emergency Contact: _____Relationship to Patient: _____ Phone: _____

I hereby give my consent for Pinnacle Plastic Surgery Associates, LLC to release my protected health information to the following family members and/or friends:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Message can be left on my voicemail: Cell: Yes / No Home: Yes / No

Printed Name: _____ Date: _____

Signature: _____