THE POLACEK CENTER FOR PLASTIC SURGERY
2000 CHAPEL VIEW BOULEVARD
CRANSTON, R.I. 02920

Consent to the Use and Disclosure of Health Information for Treatment, Payment of Healthcare Operations

I understand that as part of my healthcare **Lori G. Polacek, M.D., Inc**. originates and maintains health records describing my health history, symptoms, examinations and test results, diagnoses, treatment and any plans for future care of treatment. I understand this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information of applying my diagnosis and surgical information to my bill
- A means by which third party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing of healthcare professionals

I understand and have been provided with a Notice of Information Practices. The notice provides a more complete description of information, uses and disclosure. I understand that I have the right to review the notice prior to signing this consent. I understand that the Practice reserves the right to change their notice and practices and will notify me of any changes prior to implementation. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I disclosed to carry out treatment, payment or healthcare operations and that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the practice has already taken action in reliance thereon.

I acknowledge receipt of the Notice of Information Practices for **Lori G. Polacek, M.D., Inc.**

Signature of Patient or legal representative

_____Date_____

Staff Signature

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