RIVERVIEW AESTHETIC SURGERY
Dr. Anya Kishinevsky, MD

PHI CONSENT

Patient Consent for Use and Disclosure of Protected Health Information

By signing this form, I consent to the use and disclosure of my protected health information by physician Anya Kishinevsky, MD, and the staff and business associates, strictly for the purpose of treatment, payment and healthcare operations.

I acknowledge that I have had an opportunity to review the Notice of Privacy Practices prior to signing this consent. The physicians and the staff have encouraged me to review the Notice of Privacy Practices which provides detail on how my information may be used and disclosed. The Notice of Privacy Practices may change. A current copy may be requested when I am being seen as a patient, by contacting my physician at the office.

I may request restriction on how protected health information is used and disclosed for the purposes mentioned above. I will make a request for restriction in writing. The physicians mentioned above, reserves the right to deny the request. If the request is granted, I am bound by the terms of the agreement.

I may also revoke this consent in writing; however, information on any treatment or service provided using this or prior consents may still be used or disclosed for purposes of treatment, payment, or healthcare operations. Refer to the Notice of Privacy Practices for further information.

By signing this form, I grant my consent to the medical practice to use and disclose my protected health information for the purposes of treatment, payment, and healthcare operations.

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Signature of Patient or Surrogate Decision Maker Date