CONSENT FOR USE AND DISCLOSURE OF PROTECTED INFORMATION

SECTION A: PATIENT GIVING CONSENT

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to the use and disclosure of certain protected information to carry out treatment, payment activities, and healthcare operations. You will also be consenting to the use and disclosure of your image and contact information for other limited purposes listed below, unless you choose to restrict such use. Your Consent will expire upon the end of the treating physician's practice of facial reconstructive surgery or your written revocation. There is no expiration of your Consent for the use or disclosure is for the purposes of medical or scientific research of use in Specialty Board examination absent your specific written revocation.

Notice of Privacy Practices: You have been provided a copy of our Notice of Privacy Practices and should review it carefully before you decide whether to sign this Consent. This Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

Right to Revoke: You have the right to revoke this Consent at any time by giving WFPS written notice of your revocation submitted to:
WFPS
2000 E. 116th Street, Suite 200
Carmel, Indiana 46032
The revocation must be signed by you or your legal representative. Please understand that revocation of this Consent will not affect any action WFPS took in reliance on this Consent before it received your revocation.

SECTION C: OTHER USES AND DISCLOSURES

In addition to the use and disclosure of protected health information for treatment, payment, and business operations, WFPS may wish to conduct surveys for purposes of patient satisfaction and quality assurance, seek testimonials from patients for use in public relations and advertising activities and use patient images for promotional purposes. Please initial your consent or refusal to the following:

Use or Disclosure
Photographic or video images for promotional and patient information/education in the office
Photographic or video images for promotional and patient information/education outside of the office, to include social media
Photographic or video images for medical Specialty Board in formulating its examination of applicant physicians.
Photographic or video images in professional presentations or journal publications by Dr. Winslow
Contact information for purposes of obtaining patient feedback, including testimonials for use in advertising and publication on various social media and other internet sites.*****

***The organization that receives patient contact information has entered into a Business Associate Agreement with WFPS and is required to comply with all HIPAA privacy and security requirements under that Agreement.**

SECTION D. SIGNATURE AND ACKNOWLEDGEMENT

I have had a full opportunity to read and consider the contents of this Consent form and Notice of Privacy Practices. I understand that by signing this Consent form, I am agreeing to the use and disclosure of my protected health information as set forth above.

Signature: _____ Date: _____

Relationship to Patient: _____