

***Zieg Plastic Surgery Center & Lipo Spa***

**812-471-5476**

*401 Metro Ave*

*Evansville IN 47715*

**Patient Consent Form**

I hereby consent to ZIEG PLASTIC SURGERY CENTER using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health services rendered to me or to carry out the practice's health care operations. I also consent to ZIEG PLASTIC SURGERY CENTER using or disclosing my protected health information for treatment activities provided by another health care provider, as well as the payment activities conducted by another health care provider entity. I further consent to the disclosure of my protected health information in order for another provider or health care entity to conduct health care operations including quality assessment and reviewing the competence of health care professionals.

I understand that I may request in writing that restrict how my private information (protected health information) is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound by such restrictions.

I understand that I may revoke this consent in writing at anytime, except to the extent that you have taken action relying on this consent.

I further acknowledge that ZIEG PLASTIC SURGERY CENTER has provided me a copy of it's Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my private information (protect health information).

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Signature of Patient or Parent/Guardian

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Name of Patient or Parent/Guardian (Print)

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Date

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Relationship to Patient if Minor