

**Heartland Plastic & Reconstructive Surgery, P.C.**  
**10611 Hickman Road**  
**Des Moines, IA 50322**  
**515-254-2265**

**CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION**

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**Section A: Patient Giving Consent**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_ Social Security #: \_\_\_\_\_

**Section B: PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY**

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your Protected Health Information (PHI) to carry out treatment, payment activities and healthcare operations.

Notice of privacy practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment and payment activities, healthcare operations, and of the uses and disclosures we may make of your protected health information. A copy of our Notice accompanies the consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our policy practices as described in our Notice of Privacy Practices. If we change our primary practices we will make available a revised notice that will contain the changes. Those changes may apply to any of your Private Health Information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including revisions, at any time by contacting:

Heartland Plastic Surgery, P.C.  
1061 Hickman Road  
Des Moines, IA 50322  
515-254-2265

**Right to Revoke:** You have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the above address. Please understand that revocation of this Consent will not affect any action we took in reliance of this Consent before we received your revocation, and that we may decline to treat you if you revoke this consent.

**Signature:**

I, \_\_\_\_\_, have had the opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this consent form I am giving my consent to your use and disclosure of my PHI to carry out treatment, payment activities and health care operations.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If a personal representative, on behalf of the patient signs this consent, please complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**You Are Entitled To A Copy Of This Form After You Sign It.**

