ARTISTIC PLASTIC SURGERY CENTER, PLLC.
3515 South 15th Street, Suite 101
Tacoma, WA 98405

PRIVACY PRACTICES ACKNOWLEDGMENT

A copy of our Notice of Privacy Practices will be provided for your review upon request. By signing this form, you are consenting to our use and disclosure of your Protected Health Information while carrying out treatment, payment activities and healthcare services on your behalf.

You have the right to revoke this consent at any time by submitting to our office a written notice of your revocation. Please understand that revocation of this consent will not affect any action we took before we received your revocation. However, we may elect to discontinue providing healthcare services to you if this consent is revoked.

I wish to be contacted in the following manner (please check all that apply):

Home Telephone
______ Leave message with detailed information
______ Leave message with callback number only

Mobile Telephone
______ Leave message with detailed information
______ Leave message with callback number only

Work Telephone
______ Leave message with detailed information
______ Leave message with callback number only

Written Communication
______ Mail to my home address
______ Email to this address - ____________________
______ Fax to this number - ____________________

Other ______________________________

I hereby give permission for Artistic Plastic Surgery Center, PLLC to disclose information regarding my treatment to:

① Name ______________________________
Address ______________________________
City/State/Zip ______________________________

② Name ______________________________
Address ______________________________
City/State/Zip ______________________________

I consent to the above:

Print Name ____________________ Today’s Date __________

Signature ____________________ Date of Birth __________