BOSTON CENTER FOR PLASTIC SURGERY

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Acknowledgement of Receipt
Notice of Privacy Practices

To our Patients:

The privacy or your health care information is extremely important to us. We want you to understand how we use and disclose your information and your rights to this information. We ask you to review our Notice of Privacy Practices that describes our legal duties with respect to your health information.

How we use health information:

We use information about you to:

- Provide treatment to you.
- Ensure appropriate payment for the treatment we provide, and
- Monitor the quality of our operation.

When we may disclose information:

In certain limited cases we are permitted to disclose health care information about you. Examples include when there is a serious threat to health or safety, to reduce public health risks, for health oversights, and in certain cases for law enforcement. In addition, we may disclose information to tell you about health-related services and alternative treatments, and to conduct health-related research with your permission.

Your Information Rights:

We create a record of the care we give you.

- You have the right to know how we use your health information, who we can give it to, and your rights to this information.
- You have the right to ask us to restrict uses and disclosures where we believe such restrictions will not harm you and where it is possible for us to do so.
- You have the right to confidential communication of your health information. For example, you can ask for a conversation to be held in private or for us to send a copy of your bill to a different address.
- You have the right to look at and get a copy of information in your record unless your doctor has indicated this would be harmful to you or someone else.
- You have the right to request that our records be amended if we agree it is inaccurate or incomplete.
- You have the right to ask us for a list when we have disclosed your health information to someone other than those treating you, handling your bills, for our internal operations, or when you have authorized release of information.

Please sign below that you have received our Notice of Privacy Practices. If you have any questions, please call the office 617-735-8735.

Signature of Patient of Guardian:_____ Date: _____

Print Name of Patient: _____