REVERZA Aesthetic Medicine
160 Oakway Road, Eugene, OR • 541-600-4569

HIPAA PATIENT CONSENT/ RECEIPT OF NOTICE OF PRIVACY PRACTICES FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- With this consent, Reverza may leave a message on text or email in reference to any items that assist the practice in carrying appointment reminders, messages pertaining to my clinical care.
- The Practice has a Notice of Privacy Practices and the Patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices, should it become necessary within the law.
- The Patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.
  I am a patient of Reverza Aesthetic Medicine. I hereby acknowledge receipt of Reverza Privacy Practices.

Name (please print): ________________________________

Signature: __________________________Date_________________________________

ELECTRONIC COMMUNICATION CONSENT (Optional) Please check.

______ I consent and state my preference to have the doctor and other staff at Reverza **communicate** with me by email or standard SMS messaging regarding various aspects of my medical care, which may include, but shall not be limited to clinical relevant information, results, photos, prescriptions, appointments and billing. I understand that email and standard SMS messaging are **not confidential and secure**. I further understand that, because of this, there is a risk that email and standard SMS messaging regarding my medical care might be intercepted and read by a third party.
_____ I authorize and expressly consent to receive calls **SMS/text** and voice messages delivered to my phone number placed by the Clinic, its affiliates, associates, and service providers for appointment reminders, clinic operations, telemarketing and advertising possible treatment alternatives and other health-related benefits and services.
_____ I authorize electronic notifications through **email** for promotions, newsletters.

Name___________________________ Signature ________________ Date ____________________