

Board Certified Plastic Surgeons

- Lawrence Enisman MD FACS
- Michael Freedman MD
- Celestino Sepulveda MD

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Plastic Surgeons of the Hudson Valley may use and disclose protected health information about me to carry out treatment, payment and healthcare operations. Please refer to the Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review and obtain a copy of the Notice of Privacy Practices prior to signing this consent.

With my consent, Plastic Surgeons of the Hudson Valley may call my home, cellular phone or other designated location and leave a message in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and any call pertaining to my clinical care, surgery times and laboratory results among others. Any contact information provided to the office can be used for such purposes. I prefer to be contacted in the following forms.

Leave appointment message on: Home Phone	□ Home Phone	matio	n on:
□ Cell Phone (via call/text)	☐ Cell Phone (via call/tex	t)	
□ Office voice mail	☐ Office voice mail	.()	
□ With Another Person	□ With Another Person		
□ With Another Person	□ Via Email		
OR I do not wish to receive appointment reminders.			
EMERGENCY INF	FORMATION		
Name	Relationship		
Phone			
Address C	·		
Street	City	tate	Zip Code
The following person(s) have my permission for Plastic Surgeons of the reatment:	ne Hudson Valley to discuss m		
may revoke my consent in writing except to the extent that the pract	tice has already made disclos	ures in	reliance upon my prior
consent. If I do not sign this consent, Plastic Surgeons of the Hudso	n Valley may decline to provi	ide tred	atment to me.
Signature of Patient or Legal Guardian	Ē	Date	
Please Print Name of Patient or Legal Guardian			