PATIENT PRIVACY FORM

This is notice that THOMAS J. HUBBARD, MD, INC. and THE AESTHETIC CENTER, PC participate with the privacy practice HIPAA regulations. It is our intent to protect our patient's confidentiality within all reasonable means.

The HIPAA regulations are meant to protect your personal health information. However, frequently the practice encounters patients who appoint others to call the office to arrange appointments and take care of the financial aspects of their care.

Please indicate below, if, there are any persons whom you may provide the practice authorization to release information regarding your appointments, financial and/or medical information:

Please circle any that may apply

____ Appointments Financial Medical All
Name

____ Appointments Financial Medical All
Name

Please indicate if you would like a copy of our HIPAA policy. YES / NO

This authorization will remain in effect until terminated by you, your personal representative or other individual(s) of legal entity authorized to do so by court order or law. You have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in-person or by mailing a request to:

329 Phillip Avenue Suite 101 Virginia Beach, VA 23454

Your personal health information (PHI) may be shared with providers participating in your care, authorized government agencies, insurance company (if applicable), and credit card/financing companies (should you use this means to pay).

Our practice not only respects your privacy, but your time as well. To make communication easier we offer our patients various methods of communication meant to protect your information within all reasonable means. Please check below the communications methods you authorize the practice to use while you are a patient:

HIPAA compliant ____ Cellphone ____ Fax____ Home phone ____ Work phone

Non-HIPAA compliant: ____ Text____ Email - Please provide your best email address: ____________________________

Would you like to receive periodic emails with newsletters and offers? Yes / No

__________________________________ ______________________ ______________________
Name of Patient or Legal Guardian Date of Birth Date

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Signature of Patient or Legal Guardian