



ST. CROIX PLASTIC SURGERY & MEDISPA
DR. ROBERT F. CENTENO
12 BEESTON HILL
CHRISTIANSTED, VI 00820
340-719-2777

Consent for Purposes of Treatment, Payment, and Health Care Operations

I _____, consent to the use or disclosure of my **Protected Health Information (PHI)** by St. Croix Plastic Surgery & MediSpa for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of St. Croix Plastic Surgery & MediSpa. I understand that diagnosis or treatment of me by St. Croix Plastic Surgery & MediSpa may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment, or health care operations of St. Croix Plastic Surgery & MediSpa. St. Croix Plastic Surgery & MediSpa is not required to agree to the restrictions that I may request. However, if St. Croix Plastic Surgery & MediSpa agrees to a restriction that I request, the restriction is binding on St. Croix Plastic Surgery & MediSpa and Dr. Robert F. Centeno.

I have the right to revoke this consent, in writing, at any time, except to the extent that St. Croix Plastic Surgery & MediSpa or Dr. Robert F. Centeno has taken action in reliance on this consent.

PHI includes my health information, including my demographic information, collected from me and created or received by my provider, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review St. Croix Plastic Surgery & MediSpa. Notice of Privacy Practices prior to signing this document. The St. Croix Plastic Surgery & MediSpa's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of St. Croix Plastic Surgery & MediSpa. This Notice of Privacy Practices also describes my rights and the St. Croix Plastic Surgery & MediSpa's duties with respect to my protected health information.

St. Croix Plastic Surgery & MediSpa reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting one.

_____	_____	_____
Patient Name	Patient Signature	Date
_____	_____	
Personal Representative	Authority of Personal Representative	