

**CONSENT TO THE USE AND DISCLOSURE OF
HEALTH INFORMATION FOR TREATMENT, PAYMENT,
OR HEALTHCARE OPERATIONS**

This Consent applies to the following corporations contained within *Aestique® Medical Center: Aestique® Ambulatory Surgical Center, Inc., Aestique Plastic Surgical Associates, Ltd., Aestique® Executive Healthcare, Inc., and Aestique® Executive Healthcare, Inc.* doing business as *The Spa at Aestique® Medical Center*. The name “*Aestique® Medical Center*” will be used throughout this Consent to pertain to any one of the above healthcare corporations. This Consent also applies to BPW Medical Associates, P.C.

I understand that as part of my healthcare, *Aestique® Medical Center* and BPW Medical Associates, P.C. create and maintain health records describing my health history. I understand that the information may be used as:

1. a basis for planning my care and treatment;
2. a means of communication among many health professionals who contribute to my care;
3. a means by which third-party payors can verify that services billed were actually provided; and
4. a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I hereby consent to *Aestique® Medical Center's* and BPW Medical Associates, P.C.'s use and disclosure of my individually identifiable health information for the purposes listed above and other purposes relating to my treatment, the payment of my health care, and other health care operations of *Aestique® Medical Center* and BPW Medical Associates, P.C. In addition, I acknowledge that I received on the date indicated below a copy of the Notice of Privacy Practices, which describes the obligations of *Aestique® Medical Center* and BPW Medical Associates, P.C. regarding its use and disclosure of my individually identifiable health information and my rights regarding this information. *Aestique® Medical Center* and BPW Medical Associates, P.C. have developed a joint Notice of their Privacy Practices and are using the joint consent form in order to simplify the administrative process for patients. However, BPW Medical Associates, P.C. and *Aestique® Medical Center* are separate legal entities. They are each separately required to comply with state and federal law. They must each comply with the Notice and this Consent Form. *Aestique® Medical Center* and BPW Medical Associates P.C. are not responsible for the other's failure to comply with the notice or this Consent Form. I also understand that *Aestique® Medical Center* and BPW Medical Associates, P.C. reserve the right to change its notice and practices. If the notice is changed, I can obtain a revised copy by asking the Receptionist. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or other healthcare operations and that the healthcare corporation I am accessing is not required to agree to the restrictions requested. If the entity does agree to such restrictions, however, the entity must comply with such restrictions.

_____ (Initial) I request the following restrictions to the use or disclosure of my health information:

Effective Date of Notice: February 1, 2004

X _____ Date: _____
Signature of patient or patient's representative

Printed name of patient's representative: _____

Relationship to patient: _____