Kevin B. Bounds, M.D.
Plastic Surgery of Virginia Beach
1815 Colonial Medical Court
Virginia Beach, Virginia 23454

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I have been given the opportunity to read and review the Notice of Privacy Practices for the office of Kevin B. Bounds, M.D., Plastic Surgery of Virginia Beach. My signature indicates that Dr. Bounds and his office staff may use and disclose protected health information (PHI) about me to carry out treatment, reimbursement and healthcare operations.

I recognize that Dr. Kevin Bounds, Plastic Surgery of Virginia Beach, reserves the right to revise its Notice of Privacy Practices at any time. A copy of the effective Notice of Privacy Practices is obtained by contacting the Privacy Officer, Gigi Bounds, at the above address.

I give my consent for Plastic Surgery of Virginia Beach to call my home or any other designated location and leave a message on voice mail or in person in reference to any items that assist the Practice in carrying out treatment, reimbursement or healthcare operations such as appointment reminders, insurance matters and calls pertaining to my clinical care. I also give consent for the Practice to mail, email, text message any communications. This includes any items that will assist the Practice in carrying out treatment, payment or healthcare operations, such as patient billing statements and general information sent from the practice.

By signing this form I am consenting to Plastic Surgery of Virginia Beach's use and disclosure of my protected health information to carry out treatment, payment and/or healthcare operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures reliant upon my prior consent. If I do not sign this consent, Dr. Kevin Bounds may decline to provide treatment to me.

Patient Name: _____

Signature of Patient or Legal Guardian: _____

Name of Legal Guardian if Applicable: _____

Date: _____

Listed below are individuals who I have authorized to receive information about my Protected Health Information (PHI). This can be revoked at any time by written request. If an individual is not listed below we are unable to release any Healthcare information to them.

Name: _____ Relationship: _____ Date:_____

Name: _____ Relationship: _____Date:_____

Name: _____ Relationship: _____ Date:_____