COSMETIC SURGERY & DERMATOLOGY OF ISSAQUAH, INC.

Notice of Privacy Practices

We keep a record of the health care services we provide you. You may ask to see or receive a copy of that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information. You may request a complete copy of our **Notice of Privacy Practices** or access this document on our website at www.drmichalak.com.

By my signatures below I acknowledge access to Notice of Privacy Practices.

_____ _____

Signature of patient or authorized representative Date

_____ _____ _____

Printed Name Relationship (parent, legal guardian, representative, etc.

CONSENT TO LEAVE MESSAGES

I, _____ give Cosmetic Surgery & Dermatology of Issaquah, Inc.
Print Name

Permission to:

	Please Circle	
Leave a message regarding my upcoming office visit, Account information, and/or test results on my Answering machine.	**YES**	**NO**
Leave a message with someone who may answer the phone at my residence.	**YES**	**NO**
Leave a message at my place of employment.	**YES**	**NO**

_____

Signature

I authorize Cosmetic Surgery & Dermatology of Issaquah, Inc. to disclose information and or review my care with:

_____

Name Relationship

Important please provide us with Name & Number of Preferred Pharmacy

_____ _____

Pharmacy Name Pharmacy Number

_____

Signature (This form will be retained in your medical record)