



**G. Marc Wetherington, M.D., F.A.C.S.**

**Consent for Use and Disclosure of Health Information**

By signing this form, you are granting consent to Wetherington Plastic Surgery Center and physicians to use and disclose your protected health information for the purposes of treatment, payment and healthcare operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our office at (706) 235-5119.

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or healthcare operations. We are not required by law to grant your request. However, if we do decide to grant your request we are bound by our agreement.

You have a right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

**Patient Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

**Notice of Privacy Practices Given:** \_\_\_\_\_