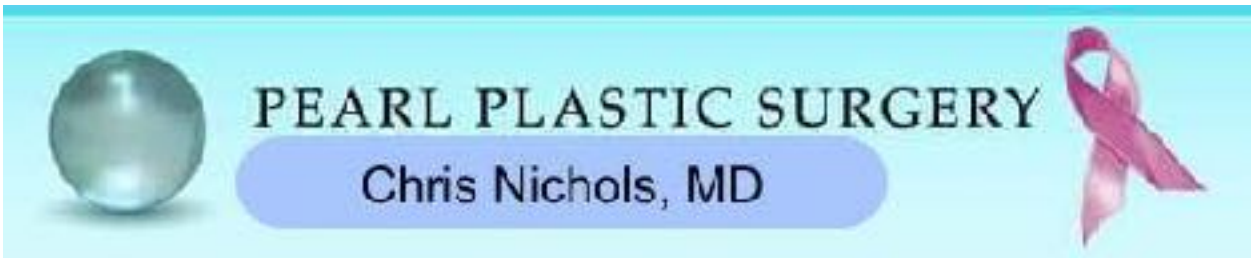

Medication History Notice:

I, _____, understand that my physician may need access to my medication history and may work on conjunction with my pharmacy and/or insurance carrier on order to provide accurate medical treatment.

Please check one below:

I give consent for my provider access my medication history
I DO NOT give consent for my provider to access my medication history

Patient Signature: _____ Date of Birth: _____

Personal Representative Signature: _____ Date: _____

Notice of Privacy Practice Acknowledgement

We Keep records of the health care services we provide to you. You may ask to see and copy that record in person or through the patient portal in ATHENA. You may also ask to have that record corrected. 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. You can get more information about it by contacting the Clinic Privacy Officers listed below.

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.

I have read & received the ***Notice of Privacy Practices***. I have had the opportunity to ask questions and have had my questions answered to my satisfaction.

Patient Name:
_____

Patient Signature: _____ Relationship to Patient:
_____

PEARL PLASTIC SURGERY

Chris Nichols, MD