

**Mountain Brook Plastic Surgery & Laser Center  
Sherry S. Collawn, M.D., Ph.D.**

**Confidentiality of your medical information is important to us.  
How may we communicate with you?**

We want to inform you of your right to an alternative mean of communication. You have the right to request an alternative mean of communication. For instance, if you have caller identification on your home telephone, you may request that we communicate with you via your office telephone number or cellular telephone. **We will do our best to honor reasonable requests for alternative means of communication. However, we are not liable for any re-disclosures i.e. due to caller identifiers, etc.**

I request that you contact me at the following:

- Home Phone     Work Phone     Cell Phone     Other, Please specify \_\_\_\_\_  
 MBPS may communicate with me via the Internet at the following email address: \_\_\_\_\_

You can contact me at the address, phone number or e-mail indicated on the registration form. Pt's Initials \_\_\_\_\_

<b>Acknowledgement of Receipt of Mountain Brook Plastic Surgery Clinic's Notice of Privacy Practices</b>	
<input type="checkbox"/> I hereby acknowledge receipt of Mountain Brook Plastic Surgeries Notice of Privacy Practices.	
<input type="checkbox"/> The named patient refused to acknowledge receipt of the Privacy Practices Notice.	
_____	_____
<b>Patient's Signature</b>	<b>Date</b>

<b>Personal Representatives</b>	
<b>To ensure the quality of the services/treatment we provide you, please be advised that post care information will be disclosed to the individual that accompany you on the date of your visit.</b>	
<input type="checkbox"/> I hereby give MBPS permission to disclose my medical (i.e. medical and financial) information to: My spouse      Adult /Child(ren)      Parent, please specify _____ Friend, please specify _____      Other _____	
<input type="checkbox"/> MBPS may <b>NOT</b> disclose my medical (i.e. medical and financial) information to: My spouse      Adult /Child(ren)      Parent, please specify _____ Friend, please specify _____      Other _____	
<small>(If you are a minor i.e. under the age of 18, and your parent/guardian is the guarantor of your services, we may disclose your medical and financial information to them for collection of fees you owe.)</small>	
Patient Signature _____	Date _____

<b>Pre/Post Photo for Testimonial Purposes</b>	
<input type="checkbox"/> I give MBPS permission to include my before and after photos in their testimonial information to potential clients.	
<input type="checkbox"/> I give MBPS permission to use my photos in future studies/articles/abstracts/website.	
<input type="checkbox"/> I do not give MBPS permission to include my before and after photos in their testimonial information to potential clients.	
Patient Signature _____	Date _____