

*David B. Reath, M.D.* PLLC

Member, American Society of Plastic Surgeons

### **Use and Disclosure of Health Information**

I understand that as part of my healthcare, David B. Reath, M.D. originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Information Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the Notice prior to signing this consent. I understand that David B. Reath, M.D. reserves the right to change the Notice of Information Privacy Practices and should information practices change, I will be notified upon my next visit to David B. Reath, M.D.

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Signature of Patient or  
Legal Representative

Date

**The personal  
approach  
to personal  
change.**