PHILIP SCHOENFELD, M.D.

RENU

ARTFUL MEDICINE

Health Insurance Portability & Accountability Act (HIPAA)

I have been provided with a Notice of Privacy Practices, in compliance with HIPAA regulators.

I have read and understand my rights under HIPAA as provided to me by Renu Med Spa.

I authorize Renu Med Spa to contact me for the following reasons:

- Permission to call me at home, office, or mobile to confirm or reschedule an appointment or to return my message(s).
- Permission to leave appointment reminders or appointment cancellation notifcations on an answering machine, with a family member, secretary, or house hold employee.
- Permission to mail reminder postcards regarding appointments.

These services are provided as courtesy by our practice. I understand that by giving my permission for the above services, I have in no way authorized the release of any confidential medical information.

Patient Name: ____

Signature: ____

Date: __________________