PLASTIC SURGERY
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Plastic Surgery Center, P.A.
Authorization for Use and/or Disclosure of Protected Health Information

Patient Name: _____

Date of Birth: _____

1. I hereby authorize Plastic Surgery Center, P.A. to use and/or disclose the protected health information identified below in paragraph 3, as set forth here in.

2. I authorize Plastic Surgery Center, P.A. to disclose the information below in paragraph 3, to the following individuals: (you may list any friends or family members in this section)

   _____
   Name(s) of authorized person(s)and relationship to patient

   _____
   Name(s) of authorized person(s)and relationship to patient

3. The information which I am authorizing to be used and/or disclosed is (all records, billing records, partial treatments, surgeries):_____

4. Your email address is confidential and will only be used to contact you and to inform you of our upcoming promotions, specials and events.

I, the undersigned, do hereby swear that I am the above- mentioned patient or a legal representative of the above-mentioned. I have read and understand the above information.

_____ _____
Signature of Patient/ Legal Representative *Date*

_____
Printed Name of Legal Representative

_____
Description of Legal Representative to Patient