

Acct # _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Precision Plastic and Hand Surgery LLC to use or disclose my Personal Health Information (PHI) as described below. I understand that, if the organization authorized to receive my PHI is not a health plan or health care provider, the released PHI may no longer be protected by federal privacy regulation. Our Notice of Privacy Practices provides detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practice. It is available upon request.

Patient authorizes communication with family/friends regarding your **care and test results.**

Name _____ Phone # _____ Relation _____

Name _____ Phone# _____ Relation _____

Patient authorizes communication with family/friends regarding your **account and billing. Next of kin.**

Name _____ Phone # _____ Relation _____
Address: _____ City _____ State _____ Zip _____

Patient authorizes communication with a primary care physician or other physician (first and last name):

- 1. _____ M.D.
- 2. _____ M.D.

Best way to contact you regarding messages, responses, appointment reminders etc. (number 1- 5, 1 being the best)

Home phone__ Work phone__ Cell phone__ E-mail Text

May we leave a message on home voicemail? Yes No N/A

May we leave a message with whomever answers the home phone? Yes No N/A

May we call your work and leave a message with the person who answers the phone? Yes No N/A

May we leave a message on work voicemail? Yes No N/A

May we contact you via Email? Email Address: _____

May we contact you via text message? _____ Yes No N/A

May we send out your PHI to a third party system? Yes No N/A

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your PHI in reliance on your consent.

May we fax and/or email to other providers if necessary to medical care Yes No N/A

Signature of patient (or patient's representative) _____ Date _____

Printed legal name of patient (or patient's representative) _____