SHOALS PLASTIC SURGERY

PATIENT NAME____

RELEASE

AUTHORIZATION TO LEAVE MESSAGES

I authorize Shoals Plastic Surgery physicians and staff to leave messages regarding my medical condition, such as lab reports, other test results, medications, and appointment reminders on my home answering machine or cell phone voice mail. This authorization will be in effect until I have given written notice to Shoals Plastic Surgery.

Agreed_____________ Disagree______________

I authorize Shoals Plastic surgery physicians and staff to reveal verbally to the following individuals, as needed, information regarding my protected health information. I understand that once this information is disclosed to those individuals that Shoals Plastic Surgery will not have control over to whom these individuals may reveal this information. I may revoke this authorization by giving written notice to Shoals Plastic Surgery.

1. Name__________________________________ Relationship__________________________

2. Name__________________________________ Relationship__________________________

3. Name__________________________________ Relationship__________________________

4. Doctor_________________________________ Doctor_______________________________

SIGNATURE ON FILE AUTHORIZATION

I certify that the signature below shall serve as Signature on File for all insurance companies for claims file on my behalf by Shoals Plastic Surgery.

I understand that information disclosed pursuant to this release may be re-disclosed by the authorized recipient and no longer protected by the privacy rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Signed____ Date ________________________________

If patient is a minor or unable to sign, the complete the following:

Patient is a minor _______, or is unable to sign because____

Signed_______________________________Relationship______________________Date______________

Witness____