

Farahmand Plastic Surgery
CONSENT TO DISCLOSE MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

Please CHECK ONE of the Following:

_____ I give my permission to the employees of Farahmand Plastic Surgery to disclose my Protected Health Information to me **AND** the following family or friends:

NAME: _____	RELATION: _____
NAME: _____	RELATION: _____
NAME: _____	RELATION: _____
NAME: _____	RELATION: _____
NAME: _____	RELATION: _____

OR

_____ I request that all my Protected Health Information be disclosed **ONLY** to me and no other friends or family.

WHAT TYPE OF MESSAGE MAY WE LEAVE FOR YOU?

In an effort to serve you better Farahmand Plastic Surgery would like to know what type of message we may leave on your answering machine/voicemail when contacting you. It is the policy of Farahmand Plastic Surgery to call you at any phone number you provide to us. When we contact you by calling you at any phone number you have provided us:

May we leave a detailed message on your answering machine/voicemail? YES or No or NA
If no, we will leave a message with just enough information for you to call us back.

*****Please Note: We will ALWAYS leave a detailed message on your answering machine, voicemail or with anyone who answers your phone when we are contacting you to remind you of an appointment at our office.**

I understand that I may revoke or change this authorization at anytime by filling out another 'consent to Disclose Medical Information' form. I understand that I will not be denied or refused treatment if I refuse to sign this authorization. I understand that the information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by Federal and State privacy laws. I understand that I have a right to receive a copy of this authorization if I request one. I also understand that this authorization will not expire.

Signature of Patient or Personal Representative

Date

*Printed name if not signed by Patient

*Relationship/authority to Act on behalf of Patient

*If not signed by the patient you must provide FPS with a copy of the document of authority that makes you the patient's personal representative (i.e. Health Care Power of Attorney, Health Care Surrogate, Health Care Proxy, Guardian, etc.). We also need a copy of your driver license.

FPS Use only: Please post the above information in the patient's coded/sticky notes.

Posted by: _____

