PLASTIC SURGERY SPECIALISTS
DISCLOSURE TO FAMILY/FRIENDS

_______ I do not want Plastic Surgery Specialists ("Provider") to disclose any information concerning my care, treatment, or billing by Provider to individuals without my express written consent or legal authorization.

_______ I authorize Provider to disclose information related to my care and treatment to the following named individual)s):

______________________________ ______________________________
______________________________ ______________________________

_______ I authorize Provider to discuss information related to my bill with the following named individual(s):

______________________________ ______________________________
______________________________ ______________________________

The authorizations provided for above are subject to the following limitation or restrictions:

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Do we have your permission to:

Leave a message on your answering machine?	Yes	No
Leave a message at your place of employment?	Yes	No
Leave a message on your cell phone voice mail?	Yes	No

____________________________________ Date:__________ ________________
Signature Witness

I HEREBY AUTHORIZE the release of any and all medical records maintained in the office of Plastic Surgery Specialists pursuant to my care and treatment to a medical facility/practice for possible further treatment.

Signature: ________________________________ Date:______________________

I have received a copy of the Patient's Bill of Rights.

Signature:_________________________________ Date:______________________

I have been given the choice to receive information regarding Advanced Directives.

Signature:_________________________________ Date:______________________