



YOUR SIGNATURE IS REQUIRED IN EACH SECTION BELOW, PLEASE. ORIGINAL OR PHOTOSTAT OF SIGNATURE SHALL BE CONSIDERED LEGAL. THANK YOU.

I. Acknowledgment of Receipt of Notice

By signing this form, you are granting consent to Specialists in Plastic Surgery, P.A. to use and disclose your protected health information (PHI) for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practice is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our Privacy Official.

My signature below constitutes my acknowledgment that I have been provided with a copy of the Notice of Privacy Practices.

Signature of Patient or Legal Representative

Date

If signed by legal representative, relationship to patient: _____

II. Medical Benefits Authorization

I hereby authorize payment of medical benefits in my behalf, to be made directly to Specialists in Plastic Surgery, P.A., for services rendered me. I also give permission for any medical information relative to my claim, to be released to my insurance company, such as Operative Reports, Pathology Reports, Office Notes, or any other information pertinent in processing benefits for my treatment. Original or photostat of signature shall be considered legal.

Signature of Patient or Legal Representative

Date

If signed by legal representative, relationship to patient: _____