Forsyth Plastic Surgical Associates

www.forsythplasticsurgery.com

PATIENT HIPAA CONSENT FORM
Authorization to Disclose Protected Health or Billing Information

I give permission to share my health or billing information to the following:

Name:____Relationship to Patient:________________

Address:____Telephone #:__________________

Name:____Relationship to Patient:________________

Address:____Telephone #:__________________

Name:____Relationship to Patient:________________

Address:____Telephone #:__________________

Please read over and initial the following statements:

- I understand that anyone in the examination room will hear my private health information ________ initials
- I give permission to Forsyth Plastic Surgery to leave a detailed message on the following phone numbers:____ _________initials

Patient
Signature:____Date:________________

Patient Representative (if patient unable to sign or under 18):
____Date:___________________

Description of Representative’s Authority:____