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 #: __________________

Patient Signature: ____ Date: __________________

Patient Representative: ____ Date: __________________

Description of Representative's Authority: ____