FLORIDA
PLASTIC SURGERY

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:_____

Phone #_____

Name:_____

Relationship to Patient:_____

Phone #_____

Name:_____

Relationship to Patient:_____

Phone #_____

Please read over and initial the following statements:

- I give permission to Florida Plastic Surgery to leave a detailed message on the following phone numbers:

  _____ initials _____

  Patient SIgnature:_____ Date: _____