AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Full Name: ____
Please Print

Date of Birth: ___________________________ Phone Number: ________________________

I authorize the use / release of my protected health information **from Statesboro Plastic Surgery** to:

____
Name of Physician / Healthcare Facility / Other

____
Address

____
City, State, Zip Code

Purpose of Request: ☐ Personal ☐ Legal ☐ Insurance ☐ Treatment ☐ Other ___________

The request and authorization applies to the following:
_______ All medical records (including labs, x-rays, etc.)

_______ Other: ____

I understand the following:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing.
4. If the requestor or receiver is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable fee.

__________________________________ __________________________
Patient Signature Date

If this authorization is signed by a representative on behalf of the patient, complete the following:

Representative's Name: ____________________________ Relationship to Patient: _________________

1402 Brampton Ave * Statesboro, Georgia 30458 * phone 912-681-3330 * fax 912-681-3303