Plastic Surgery Center of PA

I authorize the Plastic Surgery Center of PA, Inc (PLA) to use, disclose or receive my health information only as stated below.

PATIENT NAME: _____ DATE OF BIRTH: _____

Description of information to used/disclosed/received:

PLA is authorized to disclose this health information to the following person (s):

NAME: _____

ADDRESS: _____

PLA is authorized to disclose this health information to the following person (s):

NAME: _____

ADDRESS: _____

PURPOSE FOR USE/DISCLOSURE.RECEIPT OF INFORMATION

This authorization will expire upon the following date or event.

I understand that I have the right to revoke this authorization at any time. I may not revoke it to the extent that PLA has already relied upon it, or if this authorization was signed as a condition of obtaining insurance coverage. In order to revoke this authorization, I understand that I must revoke it in writing to PLA. PLA have forms for you to use if you wish to revoke this authorization at any time before it expires.

I understand that information used or disclosed by PLA to any other person(s) under this authorization could potentially be re-disclosed by the person (s) receiving the information, and may no longer be subject to the privacy protections provided to me by law.

I understand that PLA may not require that I sign this Authorization in order to obtain treatment.

Date: _____ Signature: _____

If you are the legal representative of the person listed above, please circle off the basis for your authority and attach proof of authority.

Power of Attorney Guardian Parent of Minor
Executive/Administrator Other: _____