PLEASE CIRCLE YOUR DOCTOR'S NAME

DR. KENNETH R. BARRAZA
DR. SHELBY K. BRANTLEY
DR. CAROLYN CUSHING
DR. STEPHEN F. DAVIDSON
DR. AUBREY B. LUCAS
DR. DEV A. MANISDARAM
DR. ADRIAN R. SMITH
DR. ERIC E. WEGENER

PLASTIC & HAND SURGERY ASSOCIATES, PLLC (The Face & Body Center)
2550 Flowood Dr, Ste 102, Flowood, MS 39232
Phone: 601-939-9999 | Fax: 601-936-0945

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient's Name: _____ Prev. Name (If Applicable): _____

Date of Birth: _____ Social Security #: _____

Patient's Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

I hereby request & authorize: PLASTIC AND HAND SURGERY ASSOCIATES, PLLC to
RELEASE HEALTHCARE INFORMATION OF THE PATIENT NAMED ABOVE TO:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

INFORMATION TO BE RELEASED:

- ☐ Entire Medical Record
- ☐ Medical History, Examination, Reports
- ☐ Other (Specify): _____

PURPOSE FOR NEED OF DISCLOSURE (CHECK APPLICABLE CATEGORIES):

☐ Further Medical Care ☐ Legal Investigation of Action ☐ Personal ☐ Changing Physicians
☐ Insurance/Eligibility Benefits ☐ Other (Specify) _____

ACKNOWLEDGEMENT:

1) I understand that this authorization will expire 6 MONTHS from the date signed.
2) I understand that I may **revoke** this authorization (except to the extent that action was already taken in reliance on this signed authorization at any time by notifying **Plastic & Hand Surgery Associates, PLLC**, in writing.
3) I understand that I can **refuse to sign** this authorization and that my refusal will not affect my ability to obtain treatment, payment, or my eligibility for benefits (if applicable).
4) I may **inspect** or copy any information used or disclosed under this agreement.
5) I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

NOTE: You have the right to know specifically what information you are authorizing for release (e.g., "results of a lab test performed", or if your entire record is included, "all health information").
You have the right to know the name(s) or other identification if the person(s) or organization(s) authorized to release the information.
You have the right to know who is going to use it and the purpose it will be used.

Patient Signature or Representative: _____ Date Signed: _____

Printed Name of Patient or Representative: _____ Relationship: _____

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM

HIPPA Authorization for Release of Information

This form does not constitute legal advice and covers only federal, not state, laws.