

Richmond Plastic Surgeons

Authorization for Use or Disclosure of Protected Health Information to
Family Members and Friends

I, _____, hereby authorize Richmond
Plastic Surgeons to release protected health information and/or account information to:

Name	Relationship	Social Security Number
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____

I understand that disclosure may be made to family and friends related to my health or as needed for payment of health care services. I understand that Richmond Plastic Surgeons will only disclose information relevant to current treatment. This authorization is valid until revoked in writing.

Signature of Patient/Guardian

Date