PLASTIC SURGERY SPECIALISTS
DISCLOSURE TO FAMILY/FRIENDS

_____ I do not want Plastic Surgery Specialists ("Provider") to disclose any information concerning my care, treatment, or billing by Provider to individuals without my express written consent or legal authorization.

_____ I authorize Provider to disclose information related to my care and treatment to the following named individual(s):

_____ _____
_____ _____

_____ I authorize Provider to discuss information related to my bill with the following named individual(s):

_____ _____
_____ _____

The authorizations provided for above are subject to the following limitation or restrictions:
_____

Do we have your permission to leave a message:
On your answering machine? Yes No
At your place of employment? Yes No
Leave a message on your cell phone voice mail? Yes No

_____ Date: ___/___/_____ _____
Signature Witness

_____ I have been made aware that Plastic Surgery Specialists, P.C. is a Professional Corporation owned by David H. Lowe, M.D., Paul Buhrer, M.D., and Christopher Spittler, M.D.

I HEREBY AUTHORIZE the release of any and all medical records maintained in the office of Plastic Surgery Specialists pursuant to my care and treatment to a medical facility/practice for possible further treatment.

Signature: _____ Date: ___/___/_____

I have been given the choice to receive a copy of the Patient Rights in Making Health Care Decisions.

Signature: _____ Date: ___/___/_____

I have been given the choice to receive information regarding Advance Directives.

Signature: _____ Date: ___/___/_____

Advance Directive executed: Yes No (**Please Circle One**)

Signature: _____ Date: ___/___/_____