FACIAL PLASTIC SURGERY ASSOCIATES

HIPAA AUTHORIZATION FORM

Authorization for Release of Informa-

Section A:

I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

PATIENT NAME	ID NUMBER

Persons/organizations providing the information:

Person/organizations receiving the information:

Specific description of information (including date(s)):

Section B:

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on (MM/DD/YYYY).

DATE	INITIALS

2. I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do, it won't have any affect on any actions they took before they received the revocation.

INITIALS

Signature and Date of patient or patient's representative (Form MUST be completed before signing)

PRINTED NAME OF PATIENT'S REPRESENTATIVE:	RELATIONSHIP TO THE PATIENT:

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

By signing this document, I acknowledge that I have received a copy of Facial Plastic Surgery Associates Notice of Privacy Practices.

NAME (PRINT)	SIGNATURE	DATE

Facial Plastic Surgery Associates Office Use Only

NAME OF FPSA EMPLOYEE	DATE ACKNOWLEDGEMENT RECEIVED OR REASON ACKNOWLEDGEMENT WAS NOT OBTAINED:

NAME	DATE

Thank You for Choosing FPSA