Harris Plastic Surgery
500 Montauk Highway
Suite H
West Islip, NY 11795

AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFO

I, _____, authorize this medical practice, Harris Plastic Surgery, to disclosure, the information listed, to the individuals listed below.

I understand that information disclosed to this (these) individual(s) may re-disclose information inadvertently to other parties. The privacy of this information may not be protected under the federal privacy regulations. This practice does not take responsibility for any disclosure made by the individual(s) listed below.

You may revoke or terminate this authorization by submitting your request in writing. Please contact the Privacy Officer if you should wish to terminate or change this authorization at a later date.

Please authorize one of the below options

☐ _____ I do not authorize the disclosure of information from my chart to anyone, without my written consent, on an as needed basis. *Initials* _____

☐ _____ I authorize the disclosure of all information from my chart to names below: *Initials* _____

Name of Person	Relationship to Patient
Name of Person	Relationship to Patient

Patient Signature **Date**