SWETNAM
COSMETIC SURGERY
KNOWLEDGE · BEAUTY · RESULTS

AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

I have received a: Notice of privacy Practices from Swetnam Cosmetic. _____ (initial)

I hereby authorize the disclosure of my protected health information to the following non-healthcare related persons.

Patient _____

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Phone: _____ Phone: _____

I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations then such information may be re-disclosed by that person or entity and would no longer be protected.

I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment.

I understand that I may revoke this authorization at any time by notifying this physician's office in writing.

This authorization expires **one year from date signed below.**

_____ _____
SIGNATURE OF PATIENT OR GUARDIAN DATE

_____ _____
PRINTED NAME OF PATIENT PATIENT'S DATE OF BIRTH