HARBOR PLASTIC SURGERY
CENTER
MOHS, AESTHETIC AND RECONSTRUCTIVE SURGERY

HEALTH CARE INFORMATION RELEASE

Patient Name: _____ Date of Birth: _____

Previous Name: _____ Age: _____

MY AUTHORIZATION

You may use or disclose the following health care information (check all that apply)

- ☐ All health care information in my medical record
- ☐ Health care information in my medical record relating to the following treatment or condition: _____
- ☐ Other (e.g., x-rays, bills), specify date (s): _____

You may disclose this health care information FROM:
Name (or title) and Organization: _____
Address: _____ State: _____ Zip: _____

You may disclose this health care information TO:
Name (or title) and Organization: _____
Address: _____ State: _____ Zip: _____

This authorization ends in 90 days from the date signed

My Rights
I understand I do not have to sign this authorization in order to receive health care benefits (treatment, payment or enrollment). However I do have to sign an authorization form:

- To take part in a research study or
- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I do, it would not affect any action already taken by Harbor Plastic Surgery Center based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. (A form is available from our office.)
- Write a letter to our office.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed name if signed on behalf of the patient Relationship

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