Submit by Email Print Form

PLASTIC SURGEONS OF LEXINGTON, P.L.L.C.
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CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS.

I, _____, understand that as part of my healthcare, Plastic Surgeons of Lexington, PLLC originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I have read the Notice of Information Practices and authorize Plastic Surgeons of Lexington to disclose my protected information to the following person (s):

NAME	RELATIONSHIP

I further understand that I retain the right to revoke this authorization in writing. I fully understand and accept the terms of this authorization.

_____ _____
PATIENT DATE

_____
WITNESS