AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I give Webb Aesthetic Plastic Surgery and its providers my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations such as quality reviews.

I have been informed that I may review Webb Aesthetic Plastic Surgery's Notice of Privacy Practices for a more complete description of uses and disclosures before signing this consent. I understand that Webb Aesthetic Plastic Surgery has the right to change their privacy practices and that I may obtain any revised notices from Webb Aesthetic Plastic Surgery.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that Webb Aesthetic Plastic Surgery is not required to agree to the request. If Webb Aesthetic Plastic Surgery agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing. I understand that the consent for information already used or disclosed cannot be revoked.

I authorize the release of my protected health information to Webb Aesthetic Plastic Surgery from the following indicated parties:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Signature: _____Date: _____
Patient, parent, or legal guardian

If signed by patient representative, state relationship to patient: _____