Plastikos Plastic & Reconstructive Surgery
Plastikos Surgery Center
Millennium Healthcare
Avatar Industries
4370 Georgetown Square
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www.plastikos.com
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AUTHORIZATION TO USE AND/OR DISCLOSE PRIVATE HEALTH INFORMATION

I, _____, authorize _____to use and/or disclose my health information to:_____of

PLASTIKOS/MILLENNIUM HEALTHCARE/AVATAR INDSUTRIES
4370 GEORGETOWN SQUARE
ATLANTA, GA 30338
TELEPHONE: 770-457-4677
FAX: 770-457-4428

By checking the box(es) below, I specifically authorize the use and disclosure of the following health information and/or records, if such information and/or records exist to be released:

- □ Entire medical record
- □ Summary of medical records (physician reports: summary, history and physical, operative report, consultation, pathology report, face sheet)
- □ Medical imaging studies (x-rays, CTs, MRIs, etc.)
- □ Laboratory reports
- □ Pathology reports
- □ Transcribed hospital records
- □ Billing statements
- □ Summary of billing records (cover page of the patient billing statement for each visit)

SPECIFIC CONSENT:

*The following items must be initialed to be included in the use or disclosure of other health information:

- □ HIV/AIDS related information and/or records
- □ Mental health information and/or records
- □ Genetic testing information and/or records
- □ Communicable disease information and/or records
- □ Drug/alcohol diagnosis, treatment, and/or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information.)_____.

I understand that I may revoke this authorization at any time by notifying the provider named above in writing, but if I do, it won't have any effect on any actions the provider took before it received the revocation. I understand that the provider cannot make me sign this authorization as a condition to receive treatment. The above-named provider, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ _____
PATIENT'S SIGNATURE **DATE**