



Plastikos Plastic & Reconstructive Surgery
 Plastikos Surgery Center
 Millennium Healthcare
 Avatar Industries
 4370 Georgetown Square
 Atlanta, GA 30338
 (770) 457-4677 (Tel.)
 (770) 457-4428 (Fax)
www.plastikos.com
www.millennium-healthcare.com
www.templeofhealth.ws



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 INDSTRIES
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