**Smith Plastic Surgery**

7650 West Sahara Ave

Las Vegas, NV 89117

**Medical Information Authorization**

Print Name: \_\_\_\_\_\_ Date of Birth: / /

***Notice of Privacy Practices:*** It is our desire to communicate to you that we are taking Federal (HIPAA-Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside our office.

I authorize the personnel of Smith Plastic Surgery to release all medical information to my family members and/or friends listed below. These family members and/or friends: ***may*** or ***may not***  (circle one) schedule appointments on my behalf.

Name Relationship to Patient Phone Number(s)

Permission to leave a detailed message on an answering machine/voicemail? (circle one) YES / NO

Patient Signature Date

Witness Signature Date