

**JEV Plastic Surgery and Medical Aesthetics
HIPPA Consent Form**

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This form is used to authorize the release of protected health information in accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Completion of this document authorizes the disclosure and/or use of health information about you.

Name of Patient: _____

Date-of-Birth: _____

USE AND DISCLOSURE OF HEALTH INFORMATION.

I, _____, hereby authorize JEV Plastic Surgery and Medical Aesthetics to speak to and release information to the person(s) below.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

JEV Plastic Surgery and Medical Aesthetics **WILL NOT** speak to or release any information to anyone who is not listed above. I acknowledge that I can add or remove people from this form at any time by simply requesting to sign a new form.

Patient or Legal Representative Signature

Date: _____

Legal Representative's Relationship to Patient