Plastic + Hand
SURGICAL ASSOCIATES

Open Communication Consent

This consent allows Plastic and Hand to discuss your healthcare with another individual

Patient Name:_____ Date of Birth:_____

Name of individual:_____

Relationship to patient:_____

Phone number:_____

Please specify what medical information you allow to be communicated to designated individual:

☐	Entire Medical Record	☐	Procedure/Surgery Notes
☐	Consult/Office Visit Notes	☐	Lab/Pathology Results
☐	Billing Information	☐	Diagnostic Results
☐	Other:_____		

Check below to consent or limit release of sensitive information:

HIV	**YES**	☐	**NO**	☐
Mental Health	**YES**	☐	**NO**	☐
Substance Abuse	**YES**	☐	**NO**	☐

By Signing below, I authorize release of the information specified above. Release remains in effect until patient informs staff of a change or when a new release is signed.

Signature: _____ Date:_____