Dr. Aryeh L. Herrera M.D., F.A.C.S.

STANDING AUTHORIZATION TO DISCUSS HEALTH INFORMATION WITH DESIGNATED PERSONS*

For this authorization, "My Health Information" is any and all information relating to my course of examination and treatment. I authorize Allegheny Plastic Surgery to discuss My Health Information with:

Name: _____ Name: _____
Relationship: _____ Relationship: _____
Phone #: _____ Phone #: _____

For general information and inquiries, arranging appointments, identifying medications, discussing billing and payment, and any other related matter.

This authorization is valid for one year from date signed, unless I revoke this authorization, Allegheny Plastic Surgery may contact me to extend this authorization, but I do not have to do so.

Allegheny Plastic Surgery's medical and administrative staff are pledged to maintain strict patient confidentiality in keeping with high ethical standards and in accordance with state and federal laws. Allegheny Plastic Surgery has procedures in place to support this policy. These procedures make it very unlikely that my health information will be improperly disclosed. However, if this happens, my health information may no longer be covered by these privacy protections.

I am not required to sign this authorization. Allegheny Plastic Surgery does not condition treatment, payment, benefit eligibility or enrollment activities on the signing of this form. However, if I do not sign this authorization, Allegheny Plastic Surgery may disclose "My Health Information" as requested. I will receive a copy of this authorization upon signature.

I may revoke this authorization at any time in writing by following the guidelines on the back page of this form.

Patient Name: _____
(first) (m.i.) (last)
Signature: _____ **Date:** _____

Address: _____
_____

Phone: _____ **Birth Date:** _____

For Healthcare agent/guardian/surrogate/parent, I, _____, represent that I am the representative for the patient as circled above.
Representative's Signature: _____ **Phone:** _____
Address: _____

If you are the healthcare agent or guardian, please attach proof of your authority to act on behalf of the patient.

*Not to be used in connection with health information from substance abuse treatment programs.

By signing this authorization, I understand that health information released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc. I understand that release of psychotherapy notes requires an additional authorization.

I may revoke this authorization by mailing or faxing my written request along with a copy of the original authorization to the clinic or department where my authorization was made.

If I am unable to provide a copy of the original authorization with my request to revoke, I will provide the following information.

- **Date of authorization,**
- **Name,**
- **Address,**
- **Phone number,**
- **Medical Record number,**
- **Date of birth,**
- **Purpose of authorization,**
- **A description of the health information covered by the authorization,**
- **The person or entity authorized to use the data.**

If the form was signed by my representative, the request will also include:

- **The representative's name,**
- **Relationship,**
- **Address and**
- **Phone number.**

I understand that if I am unable to provide all of the above information, Allegheny Plastic Surgery may not be able to honor my revocation request.