



General Authorization Form for Medical Release of Medical Records

FORM 2

I understand, as a patient of Bruno I Brown Plastic Surgery ("Provider"), that my signature below gives Provider permission, to the extent necessary, to use my medical record, and to provide access to my medical record, while and after I am treated by Provider, for the reasons that follow:

1. For the purpose of providing treatment to me;
2. For the purpose of arranging for payment for my care; and
3. For the purpose of Provider's "health care operations". This last category includes such things as internal quality assessment activities, contacting other health care providers regarding treatment alternatives, evaluating provider performance, training providers of care, legal and medical review of care provided, business planning and management, customer service, resolution of internal grievances and the provision of legal and auditing services.

I understand that my permission allows Provider to transmit permissible information through any means that is reasonably secure, including via e-mail, assuming that reasonable protective measures are taken to preserve the confidentiality of the information.

I understand that I may revoke this authorization at any time, but that Provider may refuse to give me further treatment if I do so.

I understand that I have the right to request that Provider restricts how my medical information is used.

- If I wish to request a restriction, I will initial the following box: ☐ In this case, Provider will give me a separate form to fill out, which will also be used for Provider to indicate whether or not Provider agrees to the requested restriction.

I understand that I have a number of rights identified below (and listed most fully on the Patient Notice provided to me by Provider):

- The right to review, and copy, my medical record
- The right to request the amendment (changing) of my medical record
- The right to grant or deny access to my record to others
- The right to decide how information from my record will be conveyed to others
- The right to complain about how my records are handled, to the Secretary of the U.S. Department of Health and Human Services, and to Provider



- The right to revoke, in writing, any consent that I provide for access to my record
- The right to authorize Provider to give information about my care to relatives or close friends, to the extent of their involvement with my care or payment
- The right to review a record of access to my medical record

I understand that I have the right to either grant or deny access to my medical record, and that my specific written permission will be sought if access is requested for any reason not set forth above.

The provider may decide to change some of the above-stated policies, and I understand that I will be given a revised Notice if this occurs.

Sign: _____

Date: _____