RESTRICTIONS to the Release and the Disclosure
of Protected Health Information to Family and Others

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SACS
SAN ANTONIO COSMETIC SURGERY, PA
BOARD CERTIFIED PLASTIC SURGEON

Restrictions to the Release and Disclosure of Protected Health Information to Family and Others

I, _____ request the following restrictions to the release OR non-release of my Protected Health Information (PHI) to the person(s) listed below:

Please release/disclose my MEDICAL _____ and/or my FINANCIAL _____ information

To those listed below: (Print Name)	(Relation to Patient)
1.	
2.	
3.	
4.	

Please DO NOT release/disclose my MEDICAL _____ and/or my FINANCIAL _____ information

To those listed below: (Print Name)	(Relation to Patient)
1.	
2.	
3.	
4.	

☐ Do NOT release any information to anyone. Patient Signature: _____

Signatures below indicate acceptance of the above restrictions to the release/disclosure of my Protected Health Information. THIS AGREEMENT IS NOT VALID UNLESS THE INDIVIDUAL OR INDIVIDUAL'S REPRESENTATIVE AND THE PHYSICIAN OR AUTHORIZED REPRESENTATIVE OF THIS PRACTICE, San Antonio Cosmetic Surgery, PA, HAVE SIGNED BELOW.

Signatures below indicate understanding that restrictions and agreements made in this consent WILL NOT EXPIRE or TERMINATE unless either party notifies the other party, in writing, of their withdrawal of the agreements and restrictions contained in this consent.

Signatures below indicate understanding that, in the event either party terminates this consent, the PHI for dates in which this consent was valid will remain protected under the terms of agreement and restriction of the then in effect consent.

_____ _____
Print Name of Patient / Patient Representative Signature of Patient / Patient Representative

_____ _____
Print Name of Authorized Practice Representative Signature of Authorized Practice Representative

_____
Today's Date