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PLASTIC AND RECONSTRUCTIVE SURGERY

DIPLOMATE AMERICAN BOARD OF PLASTIC SURGERY

INSURANCE RELEASE / DISCLOSURE OF PROTECTED HEALTH INFORMATION:

I understand that it may become necessary to release my protected health information to insurance carriers, financial parties, credit card entities, banks, and financing companies, when requested, to facilitate payment. By signing this form, I am irrevocably consenting to allow Bryan G. Forley, M.D., P.C., to use and disclose my protected health information (including my diagnosis and the records of any treatment or examination rendered to me) to any insurance carrier, credit card entity, bank, or financing company when they request such information to process an account and assist with payment. In addition, I understand that once the services are provided, all payments received by Bryan G. Forley, M.D., P.C. are final. I also authorize direct payments to Dr. Forley of the amount due in any pending insurance claim for Basic Medical, Major Medical, and Surgical treatment or services.

________________________________ __________________________

Patient Signature Birth Date

________________________________ __________________________

Witness Signature Date

PHOTOGRAPHS:

In conjunction with the medical services which I am receiving from my physician, Bryan G. Forley, M.D., I consent that photographs may be taken of me or parts of my body, under the following conditions:

1. The photographs may be taken only with the consent of Dr. Forley and under such conditions and at such times as may be approved by him.
2. The photographs shall be taken by Dr. Forley or by someone approved by him.
3. The photographs shall be used by Dr. Forley to prepare for and evaluate surgery.
4. Photographs may be taken in the event of medical research; education or science will be benefited by their use. Such photographs and information relating to my case may be published and republished, either separately or in connection with each other. They also may be used for professional journals or medical books; or used for any other purpose, which he may deem proper in the interest of medical education, knowledge or research. This is provided, however, that it is specifically understood that in any publication or use I shall not be identified by name without express and specific consent.

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Patient Signature Birth Date

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Witness Signature Date