Lisa J. Peters, MD
PLASTIC SURGERY • MEDICAL SPA

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HIPAA Authorization Form

I, _____, have received or have been offered a copy of the Notice of
(Print Patient Name)
Privacy Practices for Lisa J. Peters, MD. I have read, understood and comply with these stipulations. I permit Lisa J. Peters, MD to use and/or release the following protected health information to my referring physician and all other necessary parties. In addition, I consent for Dr. Peters to disclose medical information to the person(s) indicated below:

_____	_____	_____
(Name)	(Relationship)	(Phone Number)
_____	_____	_____
(Name)	(Relationship)	(Phone Number)

When leaving a message, please contact me at:

☐ Home: _____ ☐ Cell: _____

☐ Work: _____ ☐ Other: _____

With: ☐ All pertinent information including appointment date, time and type, pre-operative information, post-operative information and pathology results.

☐ Only a request to call back with the office phone number

In order in correspond via email or text, please fill out the following. I give permission to be contacted by:

☐ Email:_____ ☐ Text Message: _____

By signing this form I give permission for the staff at Lisa J. Peters MD, SC to respond to any email correspondence that I initiate.

_____ _____
(Patient or Guardian Signature) (Date)