FACES OF HONOR AUTHORIZATION FOR RELEASE AND USE OF INFORMATION

I. Authorization for Use of Patient Information where disclosure is not covered by HIPAA.

I hereby unconditionally authorize disclosure to and use by The American Academy of Facial Plastic and Reconstructive Surgery and The Educational and Research Foundation for The American Academy of Facial Plastic and Reconstructive Surgery of all information related to my treatment by and relationship with Click here to enter text. that is not covered by the Health Insurance Portability and Accountability Act (HIPAA), or that is subject to an exception to that act, or for which disclosure is allowed under an exception to the Act. Without limiting the generality of the foregoing statement, such uses may include peer review and re-disclosure of the information to committees, staff, and attorneys in the course of those activities. I agree to hold the above-described persons and organizations harmless against all claims arising from their disclosure, receipt, and use of the information.

II. Further Authorization for Information covered by HIPAA.

A. Use or Disclosure of HIPAA-covered Information.

Additionally, without limiting the foregoing authorization, in the event information and its disclosure are covered by the Health Insurance Portability and Accountability Act (HIPAA), I authorize the use or disclosure of my individually identifiable health information as described below. *I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.*

Patient name ___________________________ ID Number _________________________

Persons/organizations authorized to provide the information:

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Persons/organizations authorized to receive the information:

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The American Academy of Facial Plastic and Reconstructive Surgery and The Educational and Research Foundation for The American Academy of Facial Plastic and Reconstructive Surgery

Specific description of information to be used or disclosed {including date(s)}:

____

____

Specific purpose of the disclosure:

____

____

Will the health plan or health care provider or other person or entity requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above?

☐ No

☐ Yes (describe) ____

This authorization will expire ____

B. Important Information About Your Rights under HIP AA

I have read and understood the following statements about my rights regarding information covered by HIPAA:

- I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any effect on any actions the entity took before it received the revocation.
- I may see and copy the patient records provided under Part II of this authorization and legally available for my inspection if I ask for them in writing.
- I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).
- The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity.

Note: The right to inspect and copy certain patient records arises under HIPAA and applies only to certain types of records. To the extent information is not subject to disclosure or to inspection and copying under HIP AA or is provided under Part I of this authorization, that right does not arise, and unless otherwise arising under law, I will not have that right.

____________________________________ __________________________

Signature of patient or patient's representative Date

Form MUST be completed before signing

Print name of the patient's personal representative

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Relationship to the patient, including authority for status as representative

____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

You may not use this form to release information/or treatment or payment except when the information to be released is psychotherapy notes or certain research information.

Please print, complete and sign this application and e-mail this form to Info@AAFPRS.org or FAX form to 703-299-8284, along with your FACES OF HONOR Application form.