**Lincoln Aesthetic Surgical Institute**
2222 S. 16th Street, Ste 430 Tower A • Lincoln, NE 68502
402-483-8530 • fax 402-483-8531
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## MESSAGE AUTHORIZATION

Representatives of Lincoln Aesthetic Surgical Institute are allowed to leave information regarding my status as a patient on my voice mail or answering machine. I realize this information may include pertinent health status and/or financial information.

Patient Name: _____ DOB: _____

❑ **I give permission** to leave information on my voice mail or answer machine

❑ **DO NOT** leave information on my voice mail or answer machine

❑ **DO NOT** speak to anyone about my health status

## COMMUNICATION AUTHORIZATION

Lincoln Aesthetic Surgical Institute may communicate information to the following people regarding my care as needed:

| | | Type of information | | | |
|---|---|---|---|---|---|
| | | All | Scheduling/ Appointments | Medical | Billing/ Insurance |
| Name: _____ | Relationship: _____ | ☐ | ☐ | ☐ | ☐ |
| Name: _____ | Relationship: _____ | ☐ | ☐ | ☐ | ☐ |
| Name: _____ | Relationship: _____ | ☐ | ☐ | ☐ | ☐ |

Patient or Authorization Signature: _____ Relationship: _____ Date: _____

This authorization expires upon written notice from me. I understand I have a right to revoke this authorization in writing. The authorization may be revoked in writing delivered to Lincoln Aesthetic Surgical Institute.

The information used or disclosed under this authorization may be subjected to re-disclosure by the recipient and no longer protected by federal privacy laws.