

**THE SAMRA GROUP, LLC  
COSMETIC & RECONSTRUCTIVE SURGERY**



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**Patient Protected Health Information Disclosure Authorization**

Please print.

1. Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

2. Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

3. Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Listed above are the names of relatives and/or friends with whom the physicians and staff of The Samra Group have my permission to disclose and discuss my protected health information.

Information includes my past, present, or future physical or mental health condition and related healthcare services. I understand that this authorization will remain in effect until I make a written request to rescind this permission.

Date: \_\_\_\_\_

Patient  
Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Witness: \_\_\_\_\_