Client Surgical Communication Authorization Form

The CSL Therapy Organization is a Regulatory healthcare authority dedicated to enhancing surgical healthcare and ensuring our clients' well-being. In line with the new standard of care, we ask your assistance in completing this form for our clients' post-operative therapist(s). This allows for prompt communication in case of any complications or concerns, ensuring our clients receive comprehensive care. Your cooperation is greatly appreciated.

Client Release Authorization

I, _____ *(Client full name)*, hereby authorize and consent to the release of medical information and case study details related to my surgery to my surgeon, _____ *(Surgeon's full name)*, for the purpose of post-operative care coordination and medical record documentation.

_____ I understand that the purpose of this release is to facilitate communication and collaboration between my surgeon and my post-operative care provider(s) in order to ensure the continuity and quality of my healthcare.

_____ I further understand that my medical information will be kept confidential and will only be used for the purposes described in this authorization.

This authorization is effective from the date of my signature below and will remain in effect until _____ *(Specify an End Date)*, unless I provide written revocation to _____ *(Surgeon's Practice)* in advance.

The type of data that may be released is inclusive of [but not limited to the following]:

- How much adipose was removed?
- How much adipose was grafted?
- How long was the surgery itself?
- How long it took to wake up from recovery?
- Any in-surgery complications?
- Adverse reactions?
- Day Of Surgery (DOS) Hemo?
- BMI DOS?
- Weight DOS?
- How much skin was removed?
- What type of stitches/sutures were used?
- Technology used for lipo?
- Medications prescribed?
- PreOp lab results?
- Local or general anesthesia used?

Client's Signature: _____

Date of Surgery: _____

Surgeon's Full Name: _____

Surgical Team Contact Number: _____

Surgical Team Contact Email: _____

This authorization form is in compliance with the Health Insurance Portability and Accountability Act (HIPAA) and shall only be used for the aforementioned intended purposes of facilitating communication and collaboration between the client's surgeon and post-operative care provider, as described herein.