

# **Danny Fong, M.D., P.C.**

Plastic and Reconstructive Surgery

Hand Surgery

254 Canal Street, Suite 5001

New York, NY 10013

Tel: 212-343-9009

Fax: 212-431-4856

## **AUTHORIZATION TO TREAT PATIENT**

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

**PATIENT'S NAME:** \_\_\_\_\_

I authorize Dr. Danny Fong to consult and treat my child as he sees necessary. This includes but is not limited to x-rays, casting, surgical procedures and photographs for clinical records.

While abiding by all HIPAA guidelines, such treatment may be shared with insurance companies, other physicians or healthcare professionals for the purpose of discussing the patient's condition or consulting the patient's case.

I understand that I will be responsible for the cost of any services that are not covered by my insurance company.

\_\_\_\_\_

Parent/Guardian Signature

Date

\_\_\_\_\_  
Print Name