List of Plastic Surgeons in Sarasota region.

1. Ken Leong, MD 1921 Waldemere St, Sarasota, Florida 34239, 941-262-4001
2. David Yan, MD 200 Healthcare way, suite 103, North Venice Florida, 34275, 941-261-0060
3. Charles Rodriguez, MD 329 Nokomis Ave, S, Venice Florida .34285, 941-488-7727
4. Daniel B Westawski, MD 2020 59th street, W. Blake Medical Center Hand and plastic Surgery, Bradenton Florida, 34209, 941-5672876
5. F. Nichols Gahhos, MD 135 San Marco Drive, Venice FL 34285. 941-484- 6836
6. Michael M. van Vliet, MD 2020 59th street west, Burn Clinic, Bradenton Fl 34209. 941-567 2876
7. Robin Hamlin, MD 5105 Manatee Ave W, STE 19, Bradenton, FL 34209. 941-798 9777
8. Christopher G Constance, MD, 2525 Harbor Boulevard, suite 310, Port Charlotte, FL 33952 .941-NEW-LOOK
9. Issa Baroudi, MD. 3222 Tamiami Trail, Port Charlotte, FL 339052. 941-627-5155
10. Marguerite Barnett, MD. 1715 Stickney point RD., Sarasota, FL 34231. 941-927-2447
11. Alissa Shulman, MD 1950 Arlington St. Suite 112, Sarasota, FL 34239. 941-366-5476
12. David Mobley, MD. 2255 S Tamiami Trail, Sarasota FL. 34239. 941-366-8897
13. Brian Derby, MD 2255 S Tamiami Trail, Sarasota FL 34239. 941-366 8897
14. Scott Engel, MD 2255 S Tamiami Trail Sarasota, Fl 34239. 941-366 8897
15. Christopher D Adamson, MD 5741 Bee Ridge Road, Suite 510, Sarasota Fl 34233. 941-343-9900
16. Joshua Kreithan, MD. 1 School Ave, Suite 800, Sarasota, FL 34237. 941 907 8174
17. Kristopher Hamwi, MD 5566 Broadcast Court, Sarasota, FL 34240. 941 800-2000
18. Meegan Gruber, MD. 5566 Broadcast CT. suite G, Lakewood Ranch, Fl 34240. 888-400-0086.
19. James D Kotick, MD 6310 Health Pkwy, Suite 110, Lakewood Ranch, FL 34202. 941-822-8955
20. Anna Widmeyer, MD, 1715 Stickney Point Rd, Sarasota, FL 34231. 941-927-2447
21. Jerette, Schultz, MD 1921 Waldemere St, suite 301, Sarasota, Florida 34239. 941-262-4001
22. Orlando Cicillioni, MD. 443 John Ringling Blvd., suite K, Sarasota, Florida 34236. St Armands Circle. 941 388 1110.

UNIVERSAL PATIENT AUTHORIZATION FORM FOR FULL DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT AND QUALITY OF CARE

****PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW****

Patient (name and information of person whose health information is being disclosed):

Name (First Middle Last): ______________________________

Date of Birth (mm/dd/yyyy): ______________

Address: ______________________ City: ______________ State: ______ Zip: ______

You may use this form to allow your healthcare provider to access and use your health information. Your choice on whether to sign this form will not affect your ability to get medical treatment, payment for medical treatment, or health insurance enrollment or eligibility for benefits.

By signing this form, I voluntarily authorize, give my permission and allow use and disclosure:

OF WHAT: **ALL MY HEALTH INFORMATION including any information about sensitive conditions** (if any) [See page 2 for details]

FROM WHOM: ALL information sources [See page 2 for details]

TO WHOM: Specific person(s) or organization(s) permitted to receive my information (must be a healthcare provider):

Person/Organization Name: ______________________ Phone: (   ) ______

Address: ______________________ Fax: (   ) ______

PURPOSE: To provide me with medical treatment and related services and products, and to evaluate and improve patient safety and the quality of medical care provided to all patients.

EFFECTIVE PERIOD: This authorization/permission form will remain in effect until my death or the day I withdraw my permission.

REVOKING MY PERMISSION: I can revoke my permission at any time by giving written notice to the person or organization named above in "To Whom."

In addition:

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other persons [See page 2 for details].
- **I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.**
- **I have read all pages of this form and agree to the disclosures above from the types of sources listed.**

X ______________________________ ______________________
Signature of Patient or Patient's Legal Representative Date Signed (mm/dd/yyyy)

____
Print Name of Legal Representative (if applicable)

Check one to describe the relationship of Legal Representative to Patient (if applicable):

- ☐ Parent of minor
- ☐ Guardian
- ☐ Other personal representative (explain: ______________________)

NOTE: This form is invalid if modified. You are entitled to get a copy of this form after you sign it.

Explanation of Form Florida AHCA FC4200-004

"Universal Patient Authorization for Full Disclosure of Health Information for Treatment & Quality of Care"

Laws and regulations require that some sources of personal information have a signed authorization or permission form before releasing it. Also, some laws require specific authorization for the release of information about certain conditions and from educational sources.

"Of What": includes ALL YOUR HEALTH INFORMATION, INCLUDING:

1. **All records and other information regarding your health history, treatment, hospitalization, tests, and outpatient care. This information may relate to sensitive health conditions (if any), including but not limited to:**
   a. Drug, alcohol, or substance abuse
   b. Psychological, psychiatric or other mental impairment(s) or developmental disabilities (excludes "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501)
   c. Sickle cell anemia
   d. Birth control and family planning
   e. Records which may indicate the presence of a communicable disease or noncommunicable disease; and tests for or records of HIV/AIDS or sexually transmitted diseases or tuberculosis
   f. Genetic (inherited) diseases or tests
2. **Copies of educational tests or evaluations, including Individualized Educational Programs, assessments, psychological and speech evaluations, immunizations, recorded health information (such as height, weight), and information about injuries or treatment.**
3. **Information created before or after the date of this form.**

"From Whom" includes: **All information sources** including but not limited to medical and clinical sources (hospitals, clinics, labs, pharmacies, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, Veterans Affairs health care facilities, state registries and other state programs, all educational sources that may have some of my health information (schools, records administrators, counselors, etc.), social workers, rehabilitation counselors, insurance companies, health plans, health maintenance organizations, employers, pharmacy benefit managers, worker's compensation programs, state Medicaid, Medicare and any other governmental program.

"To Whom": For those health care providers listed in the "TO WHOM" section, your permission would also include physicians, other health care providers (such as nurses) and medical staff who are involved in your medical care at that organization's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purpose(s) permitted by this form for that organization or person that you specified. Disclosure may be of health information in paper or oral form or may be through electronic interchange.

"Purpose": Your signature on this form does NOT allow health insurers to have access to your health information for the purpose of deciding to give you health insurance or pay your bills. You can make that choice in a separate form that health insurers use.

"Revocation": You have the right to revoke this authorization and withdraw your permission at any time regarding any future uses by giving written notice. This authorization is automatically revoked when you die. You should understand that organizations that had your permission to access your health information may copy or include your information in their own records. These organizations, in many circumstances, are not required to return any information that they were provided nor are they required to remove it from their own records.

"Re-disclosure of Information": Any health information about you may be re-disclosed to others only to the extent permitted by state and federal laws and regulations. You understand that once your information is disclosed, it may be subject to lawful re-disclosure, in accordance with applicable state and federal law, and in some cases, may no longer be protected by federal privacy law.

Limitations of this Form: If you want your health information shared for purposes other than for treating you or you want only a portion of your health information shared, you need to use Form Florida AHCA FC4200-005 (Universal Patient Authorization Form For Limited Disclosure of Health Information), instead of this form. Also, this form cannot be used for disclosure of psychotherapy notes. This form does not obligate your health care provider or other person/organization listed in the "From Whom" or "To Whom" section to seek out the information you specified in the "Of What" section from other sources. Also, this form does not change current obligations and rules about who pays for copies of records.