Paul J. Talbot, MD · William L. Reno III, MD
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PATIENT HEALTH CARE DIRECTIVE

Patient Name: DOB:

This is to authorize physicians, nurses, or other employees of Plastic Surgery Center of Hattiesburg, P.A. to speak with my (spouse, son, daughter, sister, next of kin, or care givers) – name(s):

Name	Relationship
Name	Relationship
Name	Relationship

and to discuss with them the medical treatment I have been receiving from the Plastic Surgery Center and any other matters related to that medical treatment.

This authorization shall remain in effect until such time as it is withdrawn by me, in writing, regardless of the date signed.

Dated: _____

Signed: _____

Witness: _____

Patient Identification:

Print Patient's Name: _____

Social Security #: _____