# 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