PLASTIC SURGICAL ARTS
The Beauty of Transformation

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

DATE OF REQUEST: _____

PATIENT'S NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

CITY/STATE/ZIP CODE: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

CIRCLE TO OR FROM

I AUTHORIZE PLASTIC SURGICAL ARTS TO RELEASE INFORMATION **TO:**
OR
I AUTHORIZE PLASTIC SURGICAL ARTS TO OBTAIN INFORMATION **FROM:**

_____
NAME OF PROVIDER OR FACILITY

_____
ADDRESS

_____
CITY, STATE, ZIP CODE

_____
PHONE AND/OR FAX # (INCLUDE AREA CODE)

REQUESTED INFORMATION: _____

PURPOSE OF REQUEST: _____

AUTHORIZATION VALID FOR: (CHECK ONE)

_____ THIIS REQUEST ONLY.
_____ ONE YEAR FROM THE DATE OF THIS AUTHORIZATION OR _____. (INSERT DATE). THIS AUTHORIZATION APPLIES TO THE RECORDS OF THE TREATMENT RECEIVED ON OR PRIOR TO THE DATE OF THIS AUTHORIZATION.

SIGNATURE OF PATIENT OR REPRESENTATIVE: _____

DATE: _____

RELATIONSHIP TO PATIENT (IF REQUESTER IS NOT THE PATIENT): _____

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